

Room# Name: Age/Sex: Allergies:	Isolation: <input type="radio"/>	Admit Date & C/C: PMHX: HTN • HLD • CAD • PAD • AFib • CHF ___% • COPD • DM ___ • ___ Thyroid • CKD ___ • OSA	ATTENDING: TEAM:
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NEUROLOGICAL: Orientation: Ambulation:	Fever:	CARDIAC: Paced: <input type="radio"/> LVAD: <input type="radio"/> Rate: Rhythm: Pulses: Pressures:	SKIN:	TUBES/LINES/DRAINS:	MEDS/ORDERS:	
RESPIRATORY: O2: Sounds:	GI/GU: ACHS: <input type="radio"/> Diet: Last BM: Foley/Void:	MSK:	VITAL SIGNS: T : _____ HR: _____ RR: _____ BP: _____ O2: _____ BG: _____			
TIME:	INTAKE: _____ OUTPUT: _____					

K: _____
 Mg: _____
 BUN: _____
 CR: _____
 Hgb: _____
 Hct: _____
 ____ : _____

NOTES/PLAN:

Room#