IM Admission History & Physical:

Organized Your Flow - CC, HPI, Meds& allergy, PMH, SH, FH, brief ROS, Vital, PE, Labs & Images, Ass/Plan

....Keep the FLOW !!

CC: (one word/main Issue) _____

HPI: is a y/o with hx of:

Duration, Loc, Intensity, Radiation, Better/Worse, Context, Assoc

Allergies & Rxn :

Meds: PMH/ PSH :

SH :
Smoke Tobacco:
Chew Tobacco:
ETOH:
Main Support system at home:
Work Exposure/Travel

FH : DM, MI, Cancers
M - F-

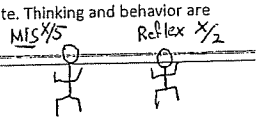
ROS:

GENERAL: Fatigue/ Weight/ Chills/ Diaphoresis/ Night/sweats/ Appetite /Fever HEENT: Vision/ hearing/ Rhinorrhea/ Congestion
CARDIO: Prior MI/ Palpitations/ Dyspnea on exertion/Edema/ Orthopnea PULM: SOB/ cough/ orthopnea/ hemoptysis/
GI: Dysphagia/ NVDC/ Melena/ Bloody stool/ Jaundice/Pain NEURO: Numbness/ tingles/ HA/ dizziness/ syncope/tremors
RENAL: Dysuria/ frequency/ stream/ flank pain Psych: Mood/depression

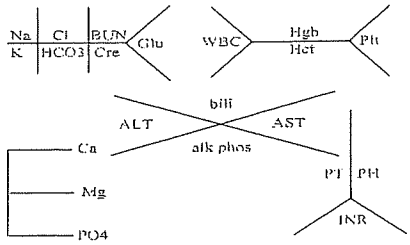
Objective: Vital and then Physical Exam

Vitals: Temp P RR BP Hgt Weight Oxygen

General: patient appears comfortable and in no acute distress.
HEENT: Head is atraumatic, normocephalic. Pupils are equal, round and reactive to light. No scleral icterus. Conjunctiva are pink and without injection. Inspection of oropharynx reveals pink, moist buccal mucosa.
Neck: Neck is supple . No Thyromegally, Bruis, No JVD
Lymphatic: There is no cervical, occipital, supraclavicular, axillary adenopathy or tenderness to palpation.
Respiratory: clear to auscultation bilaterally. No wheezes or Crackles
Cardiovascular: Regular rate and rhythm. Normal S1 and S2. No murmurs, rubs, or gallops.
Abdomen: Normal to visual inspection. Normoactive bowel sounds. Non-tender to palpation. No masses are appreciated.
Ext: Radial and dorsalis pedis pulses are 2+ bilaterally. No edema noted. No clubbing, No Cyanosis
Skin: No skin rashes or lesions to inspection or palpation.
Neurologic: Higher functions are within normal limits. No obvious defects in speech, language and memory. Cranial nerves II through XII are grossly intact and symmetric. Sensation is intact to light touch in the upper and lower extremities bilaterally.
Musculoskeletal: Gait is normal. There is full range of motion in the upper and lower extremities bilaterally. Strength is 5/5 in all the major muscle groups in the upper and lower extremities bilaterally.
Psychiatric: The patient is alert and oriented times 3. Affect is not blunted and mood is appropriate. Thinking and behavior are appropriate.



Labs and Imaging: after the PE give lab data



BNP Troponin DDimer

Other: CT or Xray:

Assessment and Plan

is a y/o with hx of:

DDx

Problem Based Assessment/Plan:

1.

DVT prophylaxis

I (we/ the team) have discussed this plan with the patient and they are in agreement.

2.