

**Chief Complaint:**

**History of Present Illness:**

Onset:  
Timing (duration, frequency):  
Location:  
Severity:  
Context:  
Modifiers:

**PMH/PSH:**

**Social Hx:**

Tob:  Y  N \_\_\_\_\_ EtOH:  Y  N \_\_\_\_\_  
Married?  Y  N Job: \_\_\_\_\_  
Kids: M \_\_\_ F \_\_\_ Location: \_\_\_\_\_

**Family Hx:**

DM HTN CA sz CVA

**ROS:**

CP/SOB/palp abd pain/ Δ in bowel/bladder  
N/V sz/syncope vertigo/tinnitus  
F/C/weight loss / difficulty swallowing/speech  
Joint aches / skin rashes psych  
 all 10 systems reviewed and negative

**Meds:**

NKDA

**Radiology:**

**Date**

**Hosp #:**

**Name:**

**Birthdate:**

**Physical Exam:**

**Appearance:**

VS:  
Cor: RRR, no m/r/g, no bruits  
Pulm: CTAB  
Abd: NT, ND, good bs  
Extr: no C/C/E

**Head:**

Inspection nl [ ] Lacerations: Location: \_\_\_\_\_ Size: \_\_\_\_\_ cm  
Palpation nl [ ]  No Bony Stepoff  
Salivary Glands: nl [ ]  Ducts intact

**Eyes:**

Vision Left: 20/ \_\_\_\_\_ Right: 20/ \_\_\_\_\_  
Intracanthal distance: \_\_\_\_\_ cm

**Ears:**

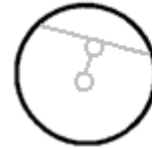
**AD**

**AS**

Auricle: nl [ ] \_\_\_\_\_ nl [ ] \_\_\_\_\_  
EAC: nl [ ] \_\_\_\_\_ nl [ ] \_\_\_\_\_  
TM mobility: nl [ ] \_\_\_\_\_ nl [ ] \_\_\_\_\_  
Hemotympanum: nl [ ] \_\_\_\_\_ nl [ ] \_\_\_\_\_

**Nose:**

External Inspection: nl [ ]  
Internal Inspection: nl [ ]  
Nasendoscopy: nl [ ]  
Active Bleeding: Ant:  L  R  
Post:  L  R  
 No Septal Hematomas



**W**

**R**

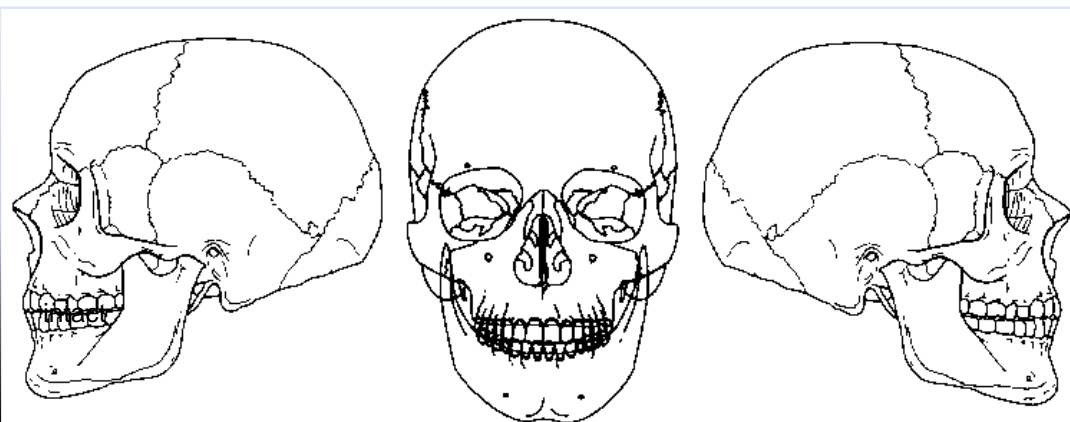
**Oral Cavity:**

Occlusion: nl [ ]  
Maxillary Mobility: nl [ ]  
Dentition: nl [ ] Lips: nl [ ]

**Neck:**

Trachea Midline  Thyroid cartilage intact  No palpable masses

**Larynx:**  TVC mobility



**Cranial Nerves:**

CNII:  VFFTC  
III/IV/VI:  EOMI  PERRL  
V:  Facial sensation nl; Corneals  
VII:  Facial strength nl  
VIII:  hearing intact; dolls eyes nl  
IX/X:  palate rise symm./gag  
XI:  SCM/trap nl  
XII:  TPM

**Assessment:**

**Plan:**

- |                             |                             |                                     |
|-----------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 5. | <input type="checkbox"/> Abx        |
| <input type="checkbox"/> 2. | <input type="checkbox"/> 6. | <input type="checkbox"/> Otic drops |
| <input type="checkbox"/> 3. | <input type="checkbox"/> 7. | <input type="checkbox"/> Procedure  |
| <input type="checkbox"/> 4. | <input type="checkbox"/> 8. | <input type="checkbox"/> Note       |