

PARA SER COMPLETADO POR EL MEDICO
(No escriba en este lado)

Nombre del Paciente _____ Fecha de Nacimiento: _____

PHYSICAL EXAM

Constitutional: T: _____ P: _____ BP: _____ RR: _____ Weight: _____ lbs Ht: _____

General Appearance: _____

Skin: no rashes, ulcers, and nodules Other _____

Eyes: normal conjunctiva, normal lids Edema Icterus Other _____

ENMT: normal teeth, lips, gums Other _____

Neck: symmetrical, normal jugular veins, no masses, no tracheal deviation Other _____

Thyroid: not palpable non-tender Other _____

Lymphatic: no adenopathy Other _____

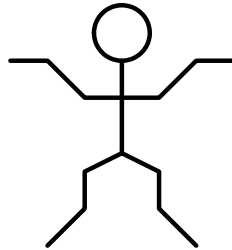
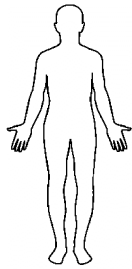
Respiratory: symmetrical chest expansion and respiratory effort, clear to auscultation Other: _____

CV: regular rhythm, no murmurs, gallops, rubs Other: _____

GI: normal bowel sounds; no tenderness or masses Other: _____

Neurological Exam

Mental Status												
Arousal	<input type="checkbox"/> Awake, alert, oriented x 4				<input type="checkbox"/> Abnormal _____							
Eye Opening	<input type="checkbox"/> Spontaneous				<input type="checkbox"/> To voice		<input type="checkbox"/> To pain		<input type="checkbox"/> None			
Commands	<input type="checkbox"/> Consistent				<input type="checkbox"/> Complex		<input type="checkbox"/> Occasional		<input type="checkbox"/> Simple		<input type="checkbox"/> None	
Language	<input type="checkbox"/> Normal				<input type="checkbox"/> Aphasia: Wernicke's _____ Broca's _____		<input type="checkbox"/> Mute, global aphasia		<input type="checkbox"/> Dysarthria			
Coordination												
Finger to nose	Right:	<input type="checkbox"/> Normal			<input type="checkbox"/> Mild		<input type="checkbox"/> Moderate		<input type="checkbox"/> Severe			
	Left:	<input type="checkbox"/> Normal			<input type="checkbox"/> Mild		<input type="checkbox"/> Moderate		<input type="checkbox"/> Severe			
Romberg	<input type="checkbox"/> Normal				<input type="checkbox"/> Abnormal							
Cranial Nerves												
I - XII	<input type="checkbox"/> Grossly Intact				<input type="checkbox"/> Abnormal							
Motor												
	<i>D</i>	<i>B</i>	<i>T</i>	<i>WF</i>	<i>WE</i>	<i>HI</i>	<i>IS</i>	<i>Q</i>	<i>H</i>	<i>PF</i>	<i>PE</i>	<i>EHL</i>
Right												
Left												
SENSORY				REFLEXES				DIAGNOSTIC STUDIES				



Primary Diagnoses:

Assessment/Plan: