

HOSPITALIST
IMPRESSION/PLAN

NOTES MUST BE DATED AND SIGNED BY PERSON MAKING ENTRIES

Allergies:		[] None
CC:	ROS:	
HEENT: Oropharynx nl: Yes/No		Mucosa nl: Yes/No
NECK: Neck Supple: Yes/No		Thyroid nl: Yes/No
Trach midline nl: Yes/No		JVD: Yes/No
APP: WNL	Obese	Cachectic
RESP: INSP: nl Kyphosis Scoliosis		
EXCURS: nl Diminished		
PALP: Resonant Dull Other:		
EFFORT: nl Acc muscle use Tachypnea		
AUSCULT: Wheeze Rhonchi Crackles		
Bronchial WNL		
CV: HR	Rhythm: Regular Irregular	
BP	Murmur: Yes/No	Rub: Yes/No
S1 S2 nl: Yes/No	Pulses nl: Yes/No	
ABD: Tender: Yes/No		Distended: Yes/No
HSM: Yes/No		Diarrhea: Yes/No
Nutrition:		
RENAL: I/O		Dialysis: Yes/No
IVF:		Diuretic:
EXT: Clubbing: Yes/No		Ecchymosis: Yes/No
Edema: Yes/No		Rash: Yes/No
NEURO: LOC: Alert: Yes/No		Oriented: Yes/No
ID: Tmax:		Cultures:
Antibiotics		
SU/DVT:		Prophylaxis:
CXR:		
LAB:		
Physician signature:		
Physician ID#		Date_____Time_____

