

Medical Staff Use:

Date: _____

Reason for Visit:

Pain / Post-procedure Comments:

(See other side for location, radiation, character, intensity)

Interim changes in:

PM/SHx NO YES _____

FHx NO YES _____

Shx NO YES _____

ROS General, Skin/Allergy, Musculoskeletal, Head, Endocrine, Respiratory, CVS,
Hematologic, Lymph, GI, GU, Neurologic, Psychiatric

Findings _____

Exam: Height: Weight: BP: Pulse: O₂sat %

Focused:

New Diagnostic Studies:

Assessment:

Plan: Meds: Functional (explain) _____
Analgesic Effect/No Evidence Addiction or No Abuse

Time: _____ Minutes

(If prolonged = reason: Explanation Counseling Pt Qns Lifestyle change

Other _____)

Signed: _____