



SYSTEM ASSESSMENT				
OBSERVATIONS AND MEASUREMENTS	NORMAL FINDINGS	ABNORMAL SIGNS	HISTORY/CURRENT MEDICAL CONDITIONS	COMMENTS
	CNS <input type="checkbox"/>	<input type="checkbox"/> Tremors <input type="checkbox"/> Dizziness <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Disoriented <input type="checkbox"/> Memory loss <input type="checkbox"/> Headache <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Pupils unequal <input type="checkbox"/> Speech slurred <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Motor/Sensory loss <input type="checkbox"/> Hemiparesis <input type="checkbox"/> Other:	<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Other dementia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Headaches <input type="checkbox"/> Depression <input type="checkbox"/> Panic attacks <input type="checkbox"/> Diabetic neuropathy <input type="checkbox"/> Other:	
	CVS <input type="checkbox"/>	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Cyanosis <input type="checkbox"/> Edema <input type="checkbox"/> Other: <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Tachycardia <input type="checkbox"/> Bradycardia	<input type="checkbox"/> CHF <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Anemia <input type="checkbox"/> Blood disorder <input type="checkbox"/> Chest pain <input type="checkbox"/> Syncope <input type="checkbox"/> Other: <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> MI <input type="checkbox"/> Angina <input type="checkbox"/> ASHD <input type="checkbox"/> VTE <input type="checkbox"/> PVD <input type="checkbox"/> Cardiac dysrhythmia	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Implanted cardioverter/defibrillator
	Resp <input type="checkbox"/>	<input type="checkbox"/> Shallow <input type="checkbox"/> Rapid <input type="checkbox"/> Slow <input type="checkbox"/> Dyspnea <input type="checkbox"/> Other: <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> SOB	<input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Other: <input type="checkbox"/> Frequent URI <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> TB	<input type="checkbox"/> Chest sounds clear <input type="checkbox"/> CPAP/BiPAP <input type="checkbox"/> Other:
	GI <input type="checkbox"/>	<input type="checkbox"/> Flatulence <input type="checkbox"/> Distension <input type="checkbox"/> Herniation <input type="checkbox"/> Obesity <input type="checkbox"/> Asymmetry <input type="checkbox"/> Constipation <input type="checkbox"/> Other: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Emesis <input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn	<input type="checkbox"/> Bulimia <input type="checkbox"/> Hiatus hernia <input type="checkbox"/> Umbilical hernia <input type="checkbox"/> Stomach pain <input type="checkbox"/> Other pain <input type="checkbox"/> Other: <input type="checkbox"/> Cholelithiasis <input type="checkbox"/> Anorexia <input type="checkbox"/> Ulcer <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> See Elimination for additional information <input type="checkbox"/> Bowel sounds normal x 4 quadrants <input type="checkbox"/> Other:
	GUR <input type="checkbox"/>	<input type="checkbox"/> Discharge <input type="checkbox"/> Lesions <input type="checkbox"/> Burning <input type="checkbox"/> Other: <input type="checkbox"/> Blood in urine	<input type="checkbox"/> Cystocele <input type="checkbox"/> Rectocele <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Sexually transmitted infection <input type="checkbox"/> Other: <input type="checkbox"/> Kidney problems <input type="checkbox"/> Renal failure <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Prostate problems	<input type="checkbox"/> See Elimination for additional information
	Integ <input type="checkbox"/>	<input type="checkbox"/> Bruising <input type="checkbox"/> Lesions <input type="checkbox"/> Abrasions <input type="checkbox"/> Cyanosis <input type="checkbox"/> Pruritus <input type="checkbox"/> Dehydrated <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundice <input type="checkbox"/> Other: <input type="checkbox"/> Dry <input type="checkbox"/> Rash <input type="checkbox"/> Pale <input type="checkbox"/> Ulcer	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Herpes zoster <input type="checkbox"/> Herpes simplex <input type="checkbox"/> Other: <input type="checkbox"/> Eczema <input type="checkbox"/> Bruises easily	<input type="checkbox"/> See Wound Record
	MS <input type="checkbox"/>	<input type="checkbox"/> Swelling <input type="checkbox"/> Deformities <input type="checkbox"/> Weakness/Atrophy <input type="checkbox"/> Other: <input type="checkbox"/> Limited ROM <input type="checkbox"/> Spasms <input type="checkbox"/> Amputation(s)	<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Gout <input type="checkbox"/> Pathological fracture: <input type="checkbox"/> Hip fracture (last 6 months): <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Other fracture (last 6 months): <input type="checkbox"/> Pain: <input type="checkbox"/> hip <input type="checkbox"/> joint <input type="checkbox"/> soft tissue <input type="checkbox"/> bone <input type="checkbox"/> Other: <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Back problems/pain	<input type="checkbox"/> See Mobility Record for additional information
	EENT <input type="checkbox"/>	<input type="checkbox"/> Deafness <input type="checkbox"/> Blurred vision <input type="checkbox"/> Nystagmus <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Other: <input type="checkbox"/> Facial paralysis <input type="checkbox"/> Aphasia <input type="checkbox"/> Dysphasia <input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Diabetic retinopathy <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Other: <input type="checkbox"/> Hearing problems <input type="checkbox"/> Sinusitis <input type="checkbox"/> Tinnitus	
	ENDO <input type="checkbox"/>	<input type="checkbox"/> Exophthalmia <input type="checkbox"/> Enlarged tongue <input type="checkbox"/> Goiter <input type="checkbox"/> Glucosuria <input type="checkbox"/> Other: <input type="checkbox"/> Polydipsia <input type="checkbox"/> Polyphagia <input type="checkbox"/> Polyuria	<input type="checkbox"/> Diabetes Mellitus Type 1 <input type="checkbox"/> Diabetes Mellitus Type 2 <input type="checkbox"/> Other: <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism	
				Date and ID

