Bed____________ Name________________________________

Age____________ DOB________________________________

Reason for Admission________________________________

Medical History________ ______________________________

Respiratory________________________________________

Activity____________ ____________________________

Elimination________________________________________

Diet Restrictions____________________________________

Allergies__________________________________________

Chemstix ( Y / N )   0800_____ 1200_____ 1600_____

DNR ( Y / N )   I&O ( Y / N )   A&O ________

Chest Pain ( Y / N )   Capillary Refill ( <3 / >3 )

Skin ___________________________ Edema _______________

Bowel Sounds ________________ Abdomen ____________

Lung Sounds RUL ____ LUL ____ RLL ____ LLL ____

| | 0800 | 1200 | 1600 |
|---|---|---|---|
| BP | | | |
| P | | | |
| R | | | |
| T | | | |
| O2 | | | |
| Pain | | | |

Other_________________ _______________________________