

CHEST EXAMINATION

INPATIENT
 OPD

NAME:
MEDICAL RECORD #:
BIRTHDATE:
PCP:

<input type="checkbox"/> PA & LATERAL <input type="checkbox"/> SINGLE VIEW - PA OR AP <input type="checkbox"/> PORTABLE CHEST - AP <input type="checkbox"/> OBLIQUES <input type="checkbox"/> DECUBITUS <input type="checkbox"/> R side down <input type="checkbox"/> L side down <input type="checkbox"/> RIBS <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT Specify Ribs# _____	TODAY'S DATE:	SEND PHYSICIAN'S PERSONAL COPY TO: NAME: _____ M.D.
	FLOOR/CLINIC	FIRST _____ LAST _____
	WHEELCHAIR <input type="checkbox"/> CART <input type="checkbox"/>	ADDRESS STREET _____ CITY _____ ZIP _____
	ICD-9 CODES	PHYSICIAN'S SIGNATURE ATTENDING _____ BEEPER _____ RESIDENT _____

DIAGNOSIS OR CLINICAL SUSPICION **(REQUIRED)**
Rule out diagnosis not acceptable

HISTORY / CLINICAL INFORMATION **(REQUIRED)**

PATIENT POTENTIALLY PREGNANT? NO YES IF YES, LMP _____

CAUTIONS/RISKS

CHECK ALL THAT APPLY **(REQUIRED)** Diagnosis or Clinical Suspicion - Symptoms

<input type="checkbox"/> Cough <input type="checkbox"/> Fever <input type="checkbox"/> Stridor <input type="checkbox"/> Abnormal sputum <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Abnormal chest sounds <input type="checkbox"/> Dysnea <input type="checkbox"/> Noncardiac edema <input type="checkbox"/> Chest pain <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumothorax <input type="checkbox"/> ARDS <input type="checkbox"/> Atelectasis <input type="checkbox"/> Pneumonia-bacterial <input type="checkbox"/> Pneumonia-aspiration <input type="checkbox"/> Lung abscess <input type="checkbox"/> Empyema <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Follow up nonspecific abnormal chest radiograph <input type="checkbox"/> Malignant neoplasm: specify _____ <input type="checkbox"/> Respirator dependant	<input type="checkbox"/> Anemia <input type="checkbox"/> Edema <input type="checkbox"/> Palpitations/tachycardia <input type="checkbox"/> Cardiac murmur <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> S/P CABG <input type="checkbox"/> S/P Aortic valve <input type="checkbox"/> S/P Mitral valve <input type="checkbox"/> S/P Pacer/AICD <input type="checkbox"/> Postop wound infection <input type="checkbox"/> S/P vascular cath insertion <input type="checkbox"/> Coronary atherosclerosis <input type="checkbox"/> Angina pectoris <input type="checkbox"/> Acute MI <input type="checkbox"/> CHF <input type="checkbox"/> Mitral v. disease <input type="checkbox"/> Aortic v. disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Pericarditis <input type="checkbox"/> Dissection of aorta <input type="checkbox"/> Acute renal failure <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Acute stroke	<input type="checkbox"/> Abdominal tenderness <input type="checkbox"/> Ascites <input type="checkbox"/> Bacteremia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Pancreatitis <input type="checkbox"/> S/P Liver transplant <input type="checkbox"/> S/P Kidney transplant <input type="checkbox"/> S/P Bone marrow transplant <input type="checkbox"/> Injury to trunk <input type="checkbox"/> Pulmonary contusion <input type="checkbox"/> Aortic trauma <input type="checkbox"/> Traumatic shock <input type="checkbox"/> Fx ribs <input type="checkbox"/> Fx clavicle or scapula or sternum <input type="checkbox"/> Fx C-spine <input type="checkbox"/> Fx T-spine <input type="checkbox"/> Fx L- spine <input type="checkbox"/> Burns <input type="checkbox"/> Concussion <input type="checkbox"/> Cerebral laceration and contusion <input type="checkbox"/> Subarachnoid, subdural, epidural <input type="checkbox"/> Coma <input type="checkbox"/> Convulsions <input type="checkbox"/> Syncope and collapse
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