Patient Evaluation Form ER:

Patient Age____ Gender M or F

Nature of ER visit___________________________________

Signs/Symptoms____
____

Allergies____

Medications____

Past Medical History____

Last Oral Intake____

Events leading up to the illness____

Onset_____________________________ Radiation___________________________________

Provocations_______________________ Severity____________________________________

Quality___________________________ Time_______________________________________

Vital Signs

B/P____________ Pulse________ Respirations____________

Room air SpO2_______ SpO2 with Oxygen_______ Blood sugar________

Lung sounds: Left Clear / Absent / Wheezing / Rales / Diminished

Right Clear / Absent / Wheezing / Rales / Diminished

Interventions

Med. administration:_______________WoundCare/Splinting______________________________

Oxygen/CPAP application:___________________BVM___________________________________

CPR:_____________________________________ Suction___________________________________