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General Exam					
Name:		Patient ID:			
Exam Date:	Exam Number:	Ht: in	Wt: lb	BSA: m ²	
Sonographer:		DOB:	Age: Yrs	Gender:	
Previous Study:		Study Location:			
Home Phone:		Pulse:		Resp Rate:	
Work Phone:		E-mail:			
Reading Physician:		Ordering Physician:			
Primary Care Physician:		Copy To:			
Medications:					
Risk Factors and Assessment:					
Procedure:					

Chief Complaint:

History of Present Illness:

Risk Factors:

Return Visit:

Hospitalizations

Date	Location	Reason

Past Medical History:

Past Surgical History

Date	Location	Reason

Family History:

Social History:

Allergies: No known drug allergies

Medications

Name	Dose	Units	Frequency

Pharmacy:

Review of Systems:

Patient Name:

Patient ID:

Exam Date:

Physical examination reveals the patient to be in no acute distress. Mood and affect are appropriate.

- **HEENT:** Extraocular movements intact, Trachea midline, Jugular venous distention normal at 6 cm. No carotid bruit. Carotid upstrokes normal to palpation.
- **Respiratory:** Accessory muscles of respiration not in use. Lungs clear without adventitial sounds. Good air entry bilaterally. No rub, rales or wheezing.
- **Cardiovascular:** Normal S1 and S2 without S3, S4. No murmurs or clicks or rub auscultated. No parasternal heave palpated.
- **Abdomen:** Soft, nontender, no organomegaly, bowel sounds present, normoactive. Abdominal aorta nonpalpable, no bruit, no masses.
- **Neurologic:** Alert and oriented x 3. Gross motor and sensory nonfocal.
- **Extremities:** No lower extremity edema. No extremity cyanosis or clubbing.

Studies Reviewed

Study Type	Location	Date	Findings
Lab			

ASSESSMENT and PLAN

Diagnosis Codes:

Cardiac Catheterization Consent: N/A

Catheterization Scheduled Date:

Studies Ordered

Study Type	Location	Date	Diagnosis Code
Lab			

Follow Up Visit:

Electronically Signed