



POBLACION HEALTH CENTER
Admission Form



Name:	FN:
Age:	Birthday:
Address:	CP Number:
Date of visit:Time of visit:	Date of visit:Time of visit:
Chief Complaint:	Chief Complaint:
S>	S>
O> BP: _____ HR: _____ RR: _____ Temp: _____ O2sat: _____ HT: _____ WT: _____ WLINE: _____ <u>SKIN:</u> <input type="checkbox"/> Pallor <input type="checkbox"/> Rashes <input type="checkbox"/> Jaundice <input type="checkbox"/> Good skin turgor OTHERS: _____ <u>HEENT:</u> <div><div><input type="checkbox"/> Anicteric sclerae <input type="checkbox"/> Pupils briskly reactive to light <input type="checkbox"/> Aural Discharge <input type="checkbox"/> Tonsillopharyngeal Congestion <input type="checkbox"/> Hypertrophic tonsils OTHERS: _____</div><div><input type="checkbox"/> Intact tympanic membrane <input type="checkbox"/> Alar flaring <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Exudates <input type="checkbox"/> Palpable mass</div><div>PM HX</div></div> <u>CHEST/LUNGS:</u> <div><div><input type="checkbox"/> Symmetrical chest expansion <input type="checkbox"/> Clear breathsounds OTHERS: _____</div><div><input type="checkbox"/> Retractions <input type="checkbox"/> Crackles/rale</div><div><input type="checkbox"/> Wheezes</div></div> <u>HEART:</u> <div><div><input type="checkbox"/> Adynamic Precordium <input type="checkbox"/> Normal rate regular rhythm OTHERS: _____</div><div><input type="checkbox"/> Heaves/thrills <input type="checkbox"/> Murmurs</div><div>FM HX</div></div> <u>ABDOMEN:</u> <div><div><input type="checkbox"/> Flat <input type="checkbox"/> Muscle Guarding</div><div><input type="checkbox"/> Flabby <input type="checkbox"/> Palpable Mass</div><div><input type="checkbox"/> Tenderness <input type="checkbox"/> Globular OTHERS: _____</div></div> <u>EXTREMITIES:</u> <div><div><input type="checkbox"/> Gross deformity <input type="checkbox"/> Full and equal pulses</div><div><input type="checkbox"/> Normal gait OTHERS: _____</div></div>	O> BP: _____ HR: _____ RR: _____ Temp: _____ O2sat: _____ HT: _____ WT: _____ WLINE: _____ <u>SKIN:</u> <input type="checkbox"/> Pallor <input type="checkbox"/> Rashes <input type="checkbox"/> Jaundice <input type="checkbox"/> Good skin turgor OTHERS: _____ <u>HEENT:</u> <div><div><input type="checkbox"/> Anicteric sclerae <input type="checkbox"/> Pupils briskly reactive to light <input type="checkbox"/> Aural Discharge <input type="checkbox"/> Tonsillopharyngeal Congestion <input type="checkbox"/> Hypertrophic tonsils OTHERS: _____</div><div><input type="checkbox"/> Intact tympanic membrane <input type="checkbox"/> Alar flaring <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Exudates <input type="checkbox"/> Palpable mass</div></div> <u>CHEST/LUNGS:</u> <div><div><input type="checkbox"/> Symmetrical chest expansion <input type="checkbox"/> Clear breathsounds OTHERS: _____</div><div><input type="checkbox"/> Retractions <input type="checkbox"/> Crackles/rale</div><div><input type="checkbox"/> Wheezes</div></div> <u>HEART:</u> <div><div><input type="checkbox"/> Adynamic Precordium <input type="checkbox"/> Normal rate regular rhythm OTHERS: _____</div><div><input type="checkbox"/> Heaves/thrills <input type="checkbox"/> Murmurs</div></div> <u>ABDOMEN:</u> <div><div><input type="checkbox"/> Flat <input type="checkbox"/> Muscle Guarding</div><div><input type="checkbox"/> Flabby <input type="checkbox"/> Palpable Mass</div><div><input type="checkbox"/> Tenderness <input type="checkbox"/> Globular OTHERS: _____</div></div> <u>EXTREMITIES:</u> <div><div><input type="checkbox"/> Gross deformity <input type="checkbox"/> Full and equal pulses</div><div><input type="checkbox"/> Normal gait OTHERS: _____</div></div>
Assessment:	Assessment:
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