

EMERGISOFT CORPORATION

ADULT NAUSEA/VOMITING/DIARRHEA

Patient Name: _____ Medical Record Number: _____ Date of Birth: _____	
MD Name: _____ Date: _____ Time: _____ AM/PM _____ PCP: _____	
Weight: _____ Chief Complaint: _____ Visit ID: _____	
Physician /MLP/ Resident HPI _____ Supervising Physician: _____ Patient is a _____ old <input type="checkbox"/> Male <input type="checkbox"/> Female	
HPI	_____ _____ _____
HISTORIAN	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Caregiver <input type="checkbox"/> EMS <input type="checkbox"/> Other _____ <input type="checkbox"/> Triage Hx Reviewed <input type="checkbox"/> Comments: _____
ONSET	<input type="checkbox"/> Min <input type="checkbox"/> Hrs _____ Days PTA: <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Other: _____
TIME COURSE	Fever TMax at home _____ F: <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Axillary <input type="checkbox"/> TM <input type="checkbox"/> Not measured <input type="checkbox"/> Felt warm <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: _____
QUALITY	<input type="checkbox"/> Nausea Last Meal: _____ Consisted of: _____ <input type="checkbox"/> Vomiting Frequency _____ Last _____ <input type="checkbox"/> Bile <input type="checkbox"/> Coffeegrounds <input type="checkbox"/> Red blood <input type="checkbox"/> Streaks <input type="checkbox"/> Clots <input type="checkbox"/> Feculent <input type="checkbox"/> Diarrhea Frequency _____ Last _____ <input type="checkbox"/> Watery <input type="checkbox"/> Dark green <input type="checkbox"/> Pink Red blood: <input type="checkbox"/> On toilet paper <input type="checkbox"/> Streaking stool <input type="checkbox"/> In water <input type="checkbox"/> All blood <input type="checkbox"/> Maroon stool <input type="checkbox"/> Black stool <input type="checkbox"/> Constipation Last BM _____ Other: _____
SEVERITY	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Previous(0-10) _____ Now(0-10) _____ Other: _____
LOCATION	<input type="checkbox"/> Cramping <input type="checkbox"/> Burning <input type="checkbox"/> Diffuse <input type="checkbox"/> Sharp <input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LLQ <input type="checkbox"/> LUQ <input type="checkbox"/> Epigastric <input type="checkbox"/> Suprapubic <input type="checkbox"/> Periumbilical Other: _____
ASSOCIATED SIGNS/ SYMPTOMS	Liquid intake: <input type="checkbox"/> None <input type="checkbox"/> Normal <input type="checkbox"/> Less Time Last: _____ Eating food: <input type="checkbox"/> None <input type="checkbox"/> Normal <input type="checkbox"/> Less Time Last: _____ Urination: <input type="checkbox"/> Normal <input type="checkbox"/> Less Last: _____ Stool: <input type="checkbox"/> Normal <input type="checkbox"/> Less Last: _____ Other: _____
CONTEXT	_____
MODIFYING FACTORS	Tylenol: Time _____ Dose: _____ mg Motrin: Time _____ Dose: _____ mg Exposure: <input type="checkbox"/> Camping _____ <input type="checkbox"/> Travel _____ <input type="checkbox"/> Well water <input type="checkbox"/> Amoeba <input type="checkbox"/> Giardia <input type="checkbox"/> C. diff <input type="checkbox"/> Salmonella <input type="checkbox"/> Shigella <input type="checkbox"/> Campylobacter <input type="checkbox"/> Yersinia <input type="checkbox"/> Staph <input type="checkbox"/> B. cereus <input type="checkbox"/> E. coli Last antibiotic use: _____ Sick contacts: _____ Recent medical care: _____ Other: _____
OTHER	_____
PMH	<input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> UTI <input type="checkbox"/> IDDM <input type="checkbox"/> NIDDM <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> RAD <input type="checkbox"/> Asthma <input type="checkbox"/> Pharyngitis <input type="checkbox"/> Strep <input type="checkbox"/> UC <input type="checkbox"/> Crohn's <input type="checkbox"/> IBD <input type="checkbox"/> GERD <input type="checkbox"/> PUD Other: _____

SURG HX	<input type="checkbox"/> Appy	ALLERGIES	<input type="checkbox"/> NKDA <input type="checkbox"/> See nurse's notes
	Other: _____		_____
SOC HX	Smoker <input type="checkbox"/> ETOH <input type="checkbox"/> Drug use <input type="checkbox"/>	MEDS	Other: _____
	Living Situation: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Family member		<input type="checkbox"/> None <input type="checkbox"/> See nurse's notes
	<input type="checkbox"/> Nursing home Other: _____		Other: _____
FAMILY HX	<input type="checkbox"/> NC / No history of inherited disorder		
IMMUNIZATIONS	Tetanus: <input type="checkbox"/> UTD <input type="checkbox"/> >5 years <input type="checkbox"/> Unknown		
	Influenza: <input type="checkbox"/> UTD <input type="checkbox"/> Never <input type="checkbox"/> Unknown		
	Pneumonia: <input type="checkbox"/> UTD <input type="checkbox"/> Never <input type="checkbox"/> Unknown		
Nursing assessment reviewed: <input type="checkbox"/> Agree with findings <input type="checkbox"/> Agree except _____			
Review of Systems: Click on box to indicate agreement, click on word to indicate opposite			
CONST	<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue	MALE GU	<input type="checkbox"/> Penile discharge <input type="checkbox"/> Penile bleeding <input type="checkbox"/> Penile pain
ENT	<input type="checkbox"/> Ear pain <input type="checkbox"/> Ear drainage <input type="checkbox"/> Nasal discharge		Testicular pain R / L / B Testicular swelling R / L / B
	<input type="checkbox"/> Sore throat <input type="checkbox"/> Mouth ulcers <input type="checkbox"/> Trouble swallowing	FEMALE GU	<input type="checkbox"/> Vag discharge <input type="checkbox"/> Abnl vag bleeding <input type="checkbox"/> Vag pain
EYES	<input type="checkbox"/> Secretions	MUSKL	<input type="checkbox"/> Back pain <input type="checkbox"/> Arthralgias <input type="checkbox"/> Myalgias <input type="checkbox"/> Bone pain
	<input type="checkbox"/> Blurred <input type="checkbox"/> Diplopia <input type="checkbox"/> Discharge <input type="checkbox"/> Purulent	SKIN	<input type="checkbox"/> Rash Character _____
RESP	<input type="checkbox"/> Icterus <input type="checkbox"/> Pain		<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Cough <input type="checkbox"/> Dyspnea <input type="checkbox"/> Wheezing <input type="checkbox"/> Stridor	NEURO	<input type="checkbox"/> Weakness <input type="checkbox"/> Paresthasias <input type="checkbox"/> Headache <input type="checkbox"/> Seizures
CARDIAC	<input type="checkbox"/> Pleuritic pain	HEME	<input type="checkbox"/> Bruising <input type="checkbox"/> Adenopathy <input type="checkbox"/> Bleeding
	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Syncope	ENDO	<input type="checkbox"/> Polyuria <input type="checkbox"/> Polydipsia <input type="checkbox"/> Weight change
GI	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea	PSYCH	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> SI <input type="checkbox"/> HI <input type="checkbox"/> Psychosis
	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Hematemesis <input type="checkbox"/> Bile	OTHER	
	<input type="checkbox"/> Black stools <input type="checkbox"/> Bloody stools		
GU	Flank pain R / L / B <input type="checkbox"/> Dysuria <input type="checkbox"/> Frequency		
	<input type="checkbox"/> Dark urine <input type="checkbox"/> Bloody urine		
REVIEWED	<input type="checkbox"/> All other systems reviewed and neg <input type="checkbox"/> Neg except as marked		
PHYSICAL EXAM: Click on box to indicate agreement, click on word to indicate opposite			
Limited by:	<input type="checkbox"/> Urgency of condition <input type="checkbox"/> Patient uncooperative <input type="checkbox"/> Altered LOC <input type="checkbox"/> Language <input type="checkbox"/> Intoxicants		
Other:	_____		
Pain Scale	0 1 2 3 4 5 6 7 8 9 10 UTR	Vital Signs reviewed/noted	
VITALS	Temp _____ BP _____ HR _____ RR _____ WT _____ FHT _____		
	Pulse Ox _____ % NL _____ Hypoxia on _____ RA _____ LPM _____		
	Interpretation: _____		
GENERAL APPEARANCE	<input type="checkbox"/> Withdrawn <input type="checkbox"/> Pale <input type="checkbox"/> Diaphoretic Distress: <input type="checkbox"/> NAD <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Other: _____	
EYES	<input type="checkbox"/> PERRLA <input type="checkbox"/> EOMI <input type="checkbox"/> Sunken <input type="checkbox"/> NL visual acuity <input type="checkbox"/> NL fundoscopic exam		
	Sclera: <input type="checkbox"/> Normal <input type="checkbox"/> injected <input type="checkbox"/> Icteric Conjunctiva: <input type="checkbox"/> Erythematous <input type="checkbox"/> Exudate <input type="checkbox"/> Petechiae	Other: _____	
HENT	<input type="checkbox"/> Head inspection NL <input type="checkbox"/> External canal clear <input type="checkbox"/> TMs NL <input type="checkbox"/> Pharynx NL <input type="checkbox"/> Nasal congestion		
	TM erythema R / L / B TM bulge R / L / B <input type="checkbox"/> Pharyngeal erythema <input type="checkbox"/> Pharyngeal exudates	Other: _____	
NECK	<input type="checkbox"/> Supple <input type="checkbox"/> Meningismus <input type="checkbox"/> Kernig's <input type="checkbox"/> Brudzinski's <input type="checkbox"/> Lymphadenopathy	Other: _____	

RESPIRATORY	<input type="checkbox"/> NL breath sounds <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Accessory muscle use <input type="checkbox"/> Retractions <input type="checkbox"/> Grunting <input type="checkbox"/> Prolonged expirations
	<input type="checkbox"/> Decreased air movement <input type="checkbox"/> Stridor <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Rales <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Wheezes <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> Diffuse
	<input type="checkbox"/> Rhonchi <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> Diffuse <input type="checkbox"/> Dyspnea: <input type="checkbox"/> On exertion <input type="checkbox"/> At rest
	Other: _____
CARDIAC	<input type="checkbox"/> Reg rate and rhythm <input type="checkbox"/> Diminished peripheral pulses <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B
	<input type="checkbox"/> Murmur <input type="checkbox"/> /VI <input type="checkbox"/> Syst / <input type="checkbox"/> Dias <input type="checkbox"/> Decreased cap refill <input type="checkbox"/> seconds
	Other: _____
ABDOMINAL	<input type="checkbox"/> Soft non-tender <input type="checkbox"/> Bowel sounds: <input type="checkbox"/> Hyper / <input type="checkbox"/> Normo / <input type="checkbox"/> Hypo <input type="checkbox"/> Tenderness <input type="checkbox"/> RUQ / <input type="checkbox"/> RLQ / <input type="checkbox"/> LUQ / <input type="checkbox"/> LLQ
	<input type="checkbox"/> Epigastric tender <input type="checkbox"/> Tender McBurney's point <input type="checkbox"/> Flank tenderness <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Rectal heme neg <input type="checkbox"/> BRBPR
	<input type="checkbox"/> Rebound <input type="checkbox"/> Involuntary guarding <input type="checkbox"/> Percussion tenderness <input type="checkbox"/> Referred pain <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Splenomegaly
	Other: _____
MALE GU	<input type="checkbox"/> NL Inspection <input type="checkbox"/> Circumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Cremasteric reflex <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B
	<input type="checkbox"/> Testicular swelling <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Hernia <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Horizontal lie <input type="checkbox"/> Testicular tenderness <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B
	<input type="checkbox"/> Balanitis <input type="checkbox"/> Phimosi s <input type="checkbox"/> Paraphimosi s <input type="checkbox"/> Penile discharge <input type="checkbox"/> Clear / <input type="checkbox"/> White / <input type="checkbox"/> Yellow
	Other: _____
FEMALE GU	<input type="checkbox"/> NL external exam <input type="checkbox"/> Erythema <input type="checkbox"/> Trauma <input type="checkbox"/> Ulcerations <input type="checkbox"/> LMP _____
	<input type="checkbox"/> Adenexal tenderness <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Mass <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Uterine tenderness
	<input type="checkbox"/> Cervical motion tenderness <input type="checkbox"/> Discharge <input type="checkbox"/> Clear / <input type="checkbox"/> Purulent / <input type="checkbox"/> Bloody <input type="checkbox"/> Cervix Open
	Other: _____
MUSCULOSKELETAL	<input type="checkbox"/> Non-tender <input type="checkbox"/> NL ROM <input type="checkbox"/> Swelling <input type="checkbox"/> Joint effusion <input type="checkbox"/> Distal pulse intact <input type="checkbox"/> Homans' sign <input type="checkbox"/> Cord neg
Other: _____	
SKIN	<input type="checkbox"/> Rash <input type="checkbox"/> Erythema <input type="checkbox"/> Jaundice <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Cyanosis <input type="checkbox"/> Pale
Other: _____	
NEUROLOGY	<input type="checkbox"/> Cranial nerves intact <input type="checkbox"/> Sensory intact <input type="checkbox"/> Motor intact <input type="checkbox"/> NL gait <input type="checkbox"/> Cerebellar intact <input type="checkbox"/> HTS <input type="checkbox"/> FTN
	<input type="checkbox"/> Reflexes 2+ symmetric <input type="checkbox"/> A&Ox4 <input type="checkbox"/> Oriented to <input type="checkbox"/> Person <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Circumstance <input type="checkbox"/> Ataxia <input type="checkbox"/> GCS: _____
	<input type="checkbox"/> Motor weakness <input type="checkbox"/> RUE / <input type="checkbox"/> RLE / <input type="checkbox"/> LUE / <input type="checkbox"/> LLE <input type="checkbox"/> Sensory abnl <input type="checkbox"/> RUE / <input type="checkbox"/> RLE / <input type="checkbox"/> LUE / <input type="checkbox"/> LLE
	Other: _____
LYMPHATIC	<input type="checkbox"/> Adenopathy <input type="checkbox"/> Cervical adenopathy <input type="checkbox"/> Axillary adenopathy <input type="checkbox"/> Groin adenopathy
Other: _____	
PSYCHOLOGY	<input type="checkbox"/> NL mood <input type="checkbox"/> NL affect <input type="checkbox"/> NL behavior <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> SI <input type="checkbox"/> HI <input type="checkbox"/> Psychosis
Other: _____	
TESTS REVIEWED	Labs reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me
	CBC _____ BMP _____ UA _____ Preg _____ GC/Chlamydia _____
	Other: _____
	ECG _____ Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me
	Xrays _____ Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me <input type="checkbox"/> Interpreted by radiologist
	CT scan _____ Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me <input type="checkbox"/> Interpreted by radiologist
	US _____ Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me <input type="checkbox"/> Interpreted by radiologist
Other: _____	
TREATMENTS	Medications: _____
	Antibiotics: _____
	Tylenol: Time _____ Dose _____ mg Motrin: Time _____ Dose _____ mg
	Other: _____

DIFFERENTIAL DIAGNOSIS	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Dehydration <input type="checkbox"/> Appendicitis <input type="checkbox"/> Peritonitis <input type="checkbox"/> Food-borne <input type="checkbox"/> Waterborne infection
	<input type="checkbox"/> SBO <input type="checkbox"/> IBD <input type="checkbox"/> Fever <input type="checkbox"/> Otitis media <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Viral illness <input type="checkbox"/> Abdominal pain <input type="checkbox"/> GERD <input type="checkbox"/> Cholecystitis
	<input type="checkbox"/> Renal colic <input type="checkbox"/> UTI <input type="checkbox"/> Pyelonephritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Pharyngitis <input type="checkbox"/> URI <input type="checkbox"/> Pneumonia <input type="checkbox"/> Gingivostomatitis
	<input type="checkbox"/> RAD <input type="checkbox"/> Asthma exacerbation <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> Chicken pox <input type="checkbox"/> Pregnancy
	Other: _____
REVISITS	Time: _____ Pain level <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> UTR
	Symptoms: <input type="checkbox"/> Same <input type="checkbox"/> Improved <input type="checkbox"/> Worse Other: _____
	Time: _____ Pain level <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> UTR
	Symptoms: <input type="checkbox"/> Same <input type="checkbox"/> Improved <input type="checkbox"/> Worse Other: _____
CONSULTATION	Time _____ <input type="checkbox"/> Surgeon <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> ID <input type="checkbox"/> Heme/Onc <input type="checkbox"/> Neuro Other: _____
	Case discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Family/SO <input type="checkbox"/> PCP Other: _____
	Time _____ <input type="checkbox"/> Surgeon <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> ID <input type="checkbox"/> Heme/Onc <input type="checkbox"/> Neuro Other: _____
	Case discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Family/SO <input type="checkbox"/> PCP Other: _____
	Time _____ <input type="checkbox"/> Surgeon <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> ID <input type="checkbox"/> Heme/Onc <input type="checkbox"/> Neuro Other: _____
	Case discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Family/SO <input type="checkbox"/> PCP Other: _____
I have reviewed: <input type="checkbox"/> Medical records <input type="checkbox"/> Prior ECGs <input type="checkbox"/> EMS report <input type="checkbox"/> NH record <input type="checkbox"/> Medical literature Other: _____	
Attending Note: After a complete review of pertinent patient findings and independent exam: <input type="checkbox"/> I concur <input type="checkbox"/> I concur except as noted; in all respects with the evaluation, treatment and disposition. Notes: _____	
CRITICAL CARE	Time excluding procedures: <input type="checkbox"/> First 30 min <input type="checkbox"/> 30-74 min <input type="checkbox"/> 75-104 min <input type="checkbox"/> 105-134 min <input type="checkbox"/> 135-164 min <input type="checkbox"/> 195 min or longer
	Total critical care time: _____ min
CLINICAL IMPRESSION	_____
DISPOSITION	<input type="checkbox"/> Admitted <input type="checkbox"/> Discharged <input type="checkbox"/> Transferred <input type="checkbox"/> Referred to ME
	Other: _____
CONDITION	<input type="checkbox"/> Improved <input type="checkbox"/> Stable <input type="checkbox"/> Unchanged <input type="checkbox"/> Expired: Time _____ <input type="checkbox"/> Notified _____

Signature: _____

Date: _____ Time: _____