

EMERGISOFT CORPORATION

HEADACHE

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 Male Female

HPI

HISTORIAN Patient Family Friend EMS Caregiver Other
 Triage Hx Reviewed Comments:

ONSET Min Hrs Days PTA: Sudden Gradual over hours Gradual over days
 Other:

TIME COURSE Constant Intermittent Better Worse Gone now
 Other:

QUALITY Similar to previous HA Throbbing Stabbing Pounding Tightness Worst HA of life
 Other:

SEVERITY Mild Moderate Severe Previous(0-10) At max(0-10) Now(0-10)
 Other:

LOCATION Frontal Parietal Occipital Temporal Left sided Right sided
 Other:

ASSOCIATED SIGNS/ SYMPTOMS None Fever Nausea Vomiting Neck pain Photophobia Weakness Eye pain
 Other:

CONTEXT Worse at home Worse at work Other:

MODIFYING FACTORS

OTHER

PMH None Migraines Chronic HA Glaucoma IDDM NIDDM HTN Other:

ALLERGIES NKDA See nurse's notes

SURG HX None Other:

Other:

SOC HX Smoker ETOH Drug use
 Living Situation: Alone Spouse/Partner Family member Nursing home Other:
 Occupation:

MEDS None See nurse's notes
 Other:

FAMILY HX NC Migraines Headaches HTN Cerebral aneurysm Stroke
 Other:

IMMUNIZATIONS Tetanus: UTD >5 years Unknown
 Influenza: UTD Never Unknown
 Pneumonia: UTD Never Unknown

Nursing assessment reviewed: Agree with findings 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	FEMALE GU	<input type="checkbox"/> Abd cramping <input type="checkbox"/> Abnl vag bleeding <input type="checkbox"/> Discharge
ENT	<input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear pain <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Sore throat	MUSKL	<input type="checkbox"/> Back pain <input type="checkbox"/> Arthralgias <input type="checkbox"/> Bone pain
EYES	<input type="checkbox"/> Vision changes <input type="checkbox"/> Discharge <input type="checkbox"/> Pain	SKIN	<input type="checkbox"/> Rash <input type="checkbox"/> Tick bite
RESP	<input type="checkbox"/> Cough <input type="checkbox"/> Dyspnea <input type="checkbox"/> Wheezing	NEURO	<input type="checkbox"/> Weakness <input type="checkbox"/> Paresthesias <input type="checkbox"/> Headache <input type="checkbox"/> Seizures
CARDIAC	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Syncope <input type="checkbox"/> LE swelling	HEME	<input type="checkbox"/> Bruising <input type="checkbox"/> Adenopathy <input type="checkbox"/> Bleeding

GI	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting	ENDO	<input type="checkbox"/> Polyuria <input type="checkbox"/> Polydipsia <input type="checkbox"/> Weight change
	<input type="checkbox"/> Black stools <input type="checkbox"/> Bloody stools	PSYCH	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> SI <input type="checkbox"/> HI <input type="checkbox"/> Psychosis
GU	Flank pain <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Dysuria	OTHER	
	<input type="checkbox"/> Dark urine <input type="checkbox"/> Bloody urine		
MALE GU	<input type="checkbox"/> Penile bleeding <input type="checkbox"/> Penile pain <input type="checkbox"/> Penile discharge		
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: Urgency of condition Patient uncooperative Altered LOC 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 _____ % <input type="checkbox"/> NL <input type="checkbox"/> Hypoxia on <input type="checkbox"/> RA <input type="checkbox"/> 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"/> NL visual acuity <input type="checkbox"/> NL fundoscopic exam Sclera: <input type="checkbox"/> Normal <input type="checkbox"/> Injected <input type="checkbox"/> Icteric
	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 <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> TM Bulge <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Temporal artery tenderness
	Other: _____
NECK	<input type="checkbox"/> Supple <input type="checkbox"/> Adenopathy <input type="checkbox"/> Thyromegaly <input type="checkbox"/> Bruits <input type="checkbox"/> Meningismus
	Other: _____
RESPIRATORY	<input type="checkbox"/> NL breath sounds/clear <input type="checkbox"/> Resp distress Other: _____
CARDIAC	<input type="checkbox"/> Reg rate and rhythm <input type="checkbox"/> Murmur <input type="checkbox"/> LE swelling
	Other: _____
ABDOMINAL	<input type="checkbox"/> Soft non-tender <input type="checkbox"/> Masses <input type="checkbox"/> NL bowel sounds <input type="checkbox"/> Rectal heme neg <input type="checkbox"/> Rectal masses
	Tender <input type="checkbox"/> RUQ / <input type="checkbox"/> RLQ / <input type="checkbox"/> LUQ / <input type="checkbox"/> LLQ <input type="checkbox"/> Epigastric tender <input type="checkbox"/> Heme pos stool CVA tender <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B
	Other: _____
MALE GU	<input type="checkbox"/> Circumcised <input type="checkbox"/> NL testicular exam Other: _____
FEMALE GU	<input type="checkbox"/> External exam NL <input type="checkbox"/> Uterine tenderness <input type="checkbox"/> Adnexal tenderness <input type="checkbox"/> R / <input type="checkbox"/> L / <input type="checkbox"/> B <input type="checkbox"/> Abnl cervical discharge
	LMP: _____ Other: _____
MUSCULOSKELETAL	<input type="checkbox"/> Non-tender <input type="checkbox"/> NL ROM <input type="checkbox"/> Swelling
	Other: _____
SKIN	<input type="checkbox"/> Rash <input type="checkbox"/> Erythema <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Cyanotic <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"/> NL reflexes
	<input type="checkbox"/> A&Ox4 Oriented to <input type="checkbox"/> Person <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Circumstance <input type="checkbox"/> Ataxia GCS: _____
	Motor weakness <input type="checkbox"/> RUE / <input type="checkbox"/> RLE / <input type="checkbox"/> LUE / <input type="checkbox"/> LLE 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 affect <input type="checkbox"/> NL behavior <input type="checkbox"/> Anxious <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 <input type="checkbox"/> BMP <input type="checkbox"/> U/A <input type="checkbox"/> LP: <input type="checkbox"/> WBC <input type="checkbox"/> RBC <input type="checkbox"/> Protein <input type="checkbox"/> Glucose <input type="checkbox"/>
	Other: _____
	ECG <input type="checkbox"/> Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me
	Rhythm Strip _____
	Xrays <input type="checkbox"/> Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me <input type="checkbox"/> Interpreted by radiologist
	CT scan <input type="checkbox"/> Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me <input type="checkbox"/> Interpreted by radiologist
	US <input type="checkbox"/> Reviewed: <input type="checkbox"/> By me <input type="checkbox"/> Interpreted by me <input type="checkbox"/> Interpreted by radiologist
	Other: _____
TREATMENTS	Medications: _____
	Antibiotics: _____
	Other: _____
DIFFERENTIAL DIAGNOSIS	<input type="checkbox"/> Migraine <input type="checkbox"/> Tension HA <input type="checkbox"/> Cluster HA <input type="checkbox"/> URI <input type="checkbox"/> Meningitis <input type="checkbox"/> Intracranial hemorrhage <input type="checkbox"/> Subarachnoid hemorrhage
	<input type="checkbox"/> Sinusitis <input type="checkbox"/> Hypertensive urgency <input type="checkbox"/> Hypertensive emergency <input type="checkbox"/> Carbon monoxide poisoning
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"/> Neurology <input type="checkbox"/> Neurosurgery Other: _____
	Case discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Family/SO <input type="checkbox"/> PCP Other: _____
	Time: _____ <input type="checkbox"/> Neurology <input type="checkbox"/> Neurosurgery Other: _____
	Case discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Family/SO <input type="checkbox"/> PCP Other: _____
	Time: _____ <input type="checkbox"/> Neurology <input type="checkbox"/> Neurosurgery 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: _____