FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

PATIENT REGISTRATION

DEMOGRAPHICS

Patient's Name: _____ SSN: _____ - _____ - _____
Last First Middle Initial

Address: _____ Address _____
(In Florida) (Up North or Mailing)

_____ _____

_____ _____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Email: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Pharmacy Name: _____ Pharmacy Phone #: ( ) _____ - _____

Phone # (Home): ( ) _____ - _____ Phone # (Cell): ( ) _____ - _____ Phone # (Work): ( ) _____ - _____

Patient's Employer: _____ Occupation: _____

Nearest Friend or Relative: _____ Relationship: _____ Phone # : ( ) _____ - _____

Primary Care Physician: _____ Phone # : ( ) _____ - _____

How did you hear about us? _____ Fax # : ( ) _____ - _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID #: _____

Insurance Address: _____ Group #: _____

_____ Group Name: _____

_____ Benefits Phone # : ( ) _____ - _____

P.A. Phone # : ( ) _____ - _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other Subscriber's D.O.B: _____ / _____ / _____

Subscriber's Name: _____ Subscriber's SSN: _____ - _____ - _____
(As it appears on your card)

Secondary Insurance: _____ Member ID #: _____

Insurance Address: _____ Group #: _____

_____ Group Name: _____

_____ Benefits Phone # : ( ) _____ - _____

P.A. Phone # : ( ) _____ - _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other Subscriber's D.O.B: _____ / _____ / _____

Subscriber's Name: _____ Subscriber's SSN: _____ - _____ - _____
(As it appears on your card)

I hereby authorize Dr. Madhavi Gunda Chunduru to discuss my medical condition and test results with my ( ) spouse; ( ) mother; ( ) father; ( ) brother; ( ) sister; ( ) son; ( ) daughter; ( ) other :_____, or ( ) none.

X _____ _____

PATIENT'S SIGNATURE **DATE**

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

*** DOCTOR TO FILL OUT SECTION BELOW ***

I hereby authorize _____, Medical Records Department, to release my medical records to:

FLORIDA KEYS CARDIOLOGY
P.O. BOX 9507
TAVERNIER, FL 33070
PHONE: (305)853-7171 I FAX: (305)853-7151

ATTENTION

IF RECORDS TOTAL MORE THAN 25 PAGES, PLEASE MAIL. THANK YOU.

The type of information to be used or disclosed is as follows:

Date(s) of service: _____

- ☐ Complete Medical Records
- ☐ History and Physical
- ☐ Operative Report
- ☐ Consultation Report
- ☐ X-Ray and Imaging Reports
- ☐ Progress Note
- ☐ Laboratory Test Results
- ☐ Other: _____

For the purpose of:

- ☐ Further Medical Care
- ☐ Legal Investigation or Action
- ☐ Changing Physicians
- ☐ Insurance Eligibility / Benefits
- ☐ Personal
- ☐ Inspection / Copying of my Records
- ☐ Other: _____

By authorizing the release of the above mentioned records, I understand that the medical records are confidential and cannot be disclosed without specific written consent of the person whom they pertain, or as permitted by law. I further understand that once released, the record custodian, or its employees have no responsibility or liability that may arise regarding any aspect of this authorization.

I also understand that I may revoke this consent in writing at any time, except where disclosure has already been made or upon occurrence of the purpose for which this disclosure is authorized.

X _____ _____

PATIENT'S SIGNATURE **DATE**

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

HEALTH INFORMATION DISCLOSURE CONSENT

New Patient Consent for Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I, _____ , understand that as part of my healthcare, my health history, symptoms, examination, test results, diagnoses, treatment, and any further care can serve as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided for.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information, uses and disclosures and understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for any of the above listed purposes.
- The right to request restrictions as to how my health information may be used, or disclosed to carry out treatment, payment, or health care operations.

I understand that Florida Keys Cardiology is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Florida Keys Cardiology reserves the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the code of Federal Regulations. Should Florida Keys Cardiology change their notice, they will send me a copy of any revised notice to the address I have provided.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

X _____ _____

PATIENT'S SIGNATURE **DATE**

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

ASSIGNMENT, RELEASE, AND BENEFITS

I hereby give consent to Dr. Madhavi Gunda Chunduru to provide whatever treatment that she may deem necessary. All professional services rendered will be charged to the patient or responsible party. Necessary forms will be completed to expedite insurance carrier payments.

I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding my medical history, treatment, or benefits payable for this claim to any organization responsible for payment on this claim.

I hereby assign Dr. Madhavi Gunda Chunduru or Florida Keys Cardiology, LLC, all payments for medical services rendered to myself.

We have contacted your insurance company. **The following is a description of your benefits. This does not represent a guarantee of benefits. This is only what your insurance company has quoted the office.** The patient is financially responsible for any and all services provided.

Effective Date of Policy: _____

Referral from PCP: ☐ Required ☐ Not Required

Office Visit Copay for a Specialist: $_____

Deductible: $_____ Amount Met: $_____ Amount Remaining: $_____

In-network:
Primary Insurance pays: _____% Secondary Insurance or Patient Pays: _____%

Out-of-network:
Primary Insurance pays: _____% Secondary Insurance or Patient Pays: _____%

Out of Pocket Maximum: $_____ Amount Met: $_____ Amount Remaining: $_____

Procedure Code
Prior Authorizations: _____ _____

_____ _____

_____ _____

_____ _____

I spoke to _____ , reference number: _____ , date: _____

Please sign and date this form to indicate that you understand and agree to your benefits and Florida Keys Cardiology's financial policy.

X _____ _____

PATIENT'S SIGNATURE **DATE**

FLORIDA KEYS CARDIOLOGY
Madhavi Gunda Chunduru, MD, F.A.C.C.
Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology
Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

ARBITRATION AGREEMENT

The patient agrees that in consideration of the discounts of the billed charges given by Florida Keys Cardiology any claim, controversy or dispute arising out of or related to this agreement shall be resolved in arbitration. If the patient did not get a discount of the billed charges the patient still agrees that all controversies relating to this agreement shall be resolved in arbitration. All arbitration shall be conducted pursuant to the rules and procedures of the American Health Lawyers Association Alternative Dispute Resolution Services Rules of procedure for Arbitration ("AHLA Arbitration Service"). This agreement to arbitrate shall continue in effect after the termination or expiration of this agreement. Within thirty (30) days from receipt of written request to arbitrate from either part, the matter shall be submitted to a single arbitrator in Miami mutually selected by the parties from a list of names to be provided by the AHLA Arbitration Service. The Parties agree that the maximum amount of damages that can be collected from this agreement limited to $1,000,000 (one million dollars) which include all punitive damages including pain and suffering. The decision of the arbitrator shall be final and binding on the parties and enforceable in any court of competent jurisdiction. All arbitration costs shall be paid equally by each party, except each party shall pay its Own attorney's and expert's fees.

X _____ _____

PATIENT'S SIGNATURE **DATE**

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

PATIENT HISTORY FORM

Patient's Name: _____ Primary Care Physician: _____

Date of Birth: _____ / _____ /_____ Age: _____

DOCTOR'S NAME	TYPE OF DOCTOR	PHONE	FAX

*** DOCTOR TO FILL OUT SECTION BELOW ***

CHIEF COMPLAINT:

HISTORY OF PRESENTING ILLNESS:

DETAILS OF CHIEF COMPLAINT:

Problem (Why are you here?): _____

When did the problem start? _____hours _____ days _____weeks_____months_____years

Location: _____

Radiation: _____

Quality: _____

Duration: _____

Timing: _____

Severity: _____

Aggravating Factors: _____

Relieving Factors: _____

Associated Signs and Symptoms: _____

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

PATIENT HISTORY FORM

ALLERGIES

DO YOU HAVE ANY ALLERGIES TO DRUGS OR FOOD?: ☐ **YES** ☐ **NO**

ALLERGY	REACTION	SEVERITY: MILD / MODERATE / SEVERE

MEDICATIONS

Please list all prescriptions and all over the counter medications including vitamins.

MEDICATION	DOSAGE	HOW OFTEN TAKEN?

SOCIAL HISTORY AND LIFESTYLE

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er

Children: ☐ Yes ☐ No I If YES, How many? _____

Highest Level of Education: ☐ High School ☐ Some College ☐ Associates ☐ Bachelors ☐ Masters ☐ Other:_____

Current / Past Job Title or Description: _____

Are you working? ☐ Yes ☐ No

If YES, ☐ Full Time ☐ Part Time

If NO, ☐ Retired ☐ Disability ☐ Unemployed ☐ On SSI ☐ Other:

Current Smoker? ☐ Yes ☐ No I If YES, How many packs/day?_____ and #of years_____ Start Date _____

Previous Smoker? ☐ Yes ☐ No I If YES, How many packs/day?_____ and #of years_____ Quit Date _____

Alcohol Use? ☐ Yes ☐ No I If YES, ☐ Beer ☐ Wine ☐ Liquor I How much daily?: _____

Caffeine Use? ☐ Yes ☐ No I If YES, ☐ Coffee ☐ Tea ☐ Energy Drinks I How much daily?:_____

Water Consumption? _____

Ilicit Drug Use (heroin, cocaine, marijuana)? ☐ Yes ☐ No I If YES, specify type and amount used daily: _____

HIV Risk Factors (homosexual, intravenous drug user, multiple sex partners?) ☐ Yes ☐ No

Do you exercise on a regular basis? ☐ Yes ☐ No I If YES, How many hours/day?_____ #days/week _____ type? _____

Are you on a special diet? ☐ Yes ☐ No I If YES, please explain: _____

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

PATIENT HISTORY FORM

PAST MEDICAL HISTORY

ANEMIA	☐ YES	☐ NO	GLAUCOMA	☐ YES	☐ NO	POST MENOPAUSAL	☐ YES	☐ NO
ANGINA / CHEST PAIN	☐ YES	☐ NO	GOUT	☐ YES	☐ NO	PSVT	☐ YES	☐ NO
ANXIETY	☐ YES	☐ NO	HEARING LOSS	☐ YES	☐ NO	PULMONARY EMBOLISM	☐ YES	☐ NO
ASTHMA / BRONCHITIS	☐ YES	☐ NO	HEART ATTACK (MI)	☐ YES	☐ NO	RADICULOPATHY	☐ YES	☐ NO
ATRIAL FIBRILLATION	☐ YES	☐ NO	HEART VALVE DISEASE	☐ YES	☐ NO	RHEUMATOID ARTHRITIS	☐ YES	☐ NO
BLEEDING PROBLEMS	☐ YES	☐ NO	HEPATITIS	☐ YES	☐ NO	SCARLET FEVER	☐ YES	☐ NO
BPH (BIG PROSTATE)	☐ YES	☐ NO	HERNIATED DISCS	☐ YES	☐ NO	SEIZURES	☐ YES	☐ NO
CANCER	☐ YES	☐ NO	HIATAL HERNIA	☐ YES	☐ NO	SEXUAL DYSFUNCTION	☐ YES	☐ NO
LOCATION: _____			HIGH BLOOD PRESSURE	☐ YES	☐ NO	SLEEP APNEA	☐ YES	☐ NO
CATARACTS	☐ YES	☐ NO	HIGH CHOLESTEROL	☐ YES	☐ NO	SPINAL STENOSIS	☐ YES	☐ NO
CHF (HEART FAILURE)	☐ YES	☐ NO	KIDNEY FAILURE	☐ YES	☐ NO	SPONDYLOLISTHESIS	☐ YES	☐ NO
COPD/EMPHYSEMA	☐ YES	☐ NO	KIDNEY STONES	☐ YES	☐ NO	STOMACH ULCERS	☐ YES	☐ NO
DEEP VEIN THROMBOSIS	☐ YES	☐ NO	LIVER DISEASE	☐ YES	☐ NO	STROKE / TIA	☐ YES	☐ NO
DEFIBRILLATOR +/- PACER	☐ YES	☐ NO	MACULAR DEGENERATION	☐ YES	☐ NO	THYROID DISEASE	☐ YES	☐ NO
DEPRESSION	☐ YES	☐ NO	MIGRAINE HEADACHE	☐ YES	☐ NO	TUBERCULOSIS	☐ YES	☐ NO
DEMENTIA	☐ YES	☐ NO	NEUROPATHY / SCIATICA	☐ YES	☐ NO	VASCULAR DISEASE	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO	OBESITY / OVERWEIGHT	☐ YES	☐ NO	VITAMIN D DEFICIENCY	☐ YES	☐ NO
DIVERTICULITIS	☐ YES	☐ NO	OSTEOARTHRITIS	☐ YES	☐ NO	VENOUS STASIS	☐ YES	☐ NO
DIVERTICULOSIS	☐ YES	☐ NO	OSTEOPENIA	☐ YES	☐ NO	_____	☐ YES	☐ NO
FATTY LIVER	☐ YES	☐ NO	OSTEOPOROSIS	☐ YES	☐ NO	_____	☐ YES	☐ NO
GERD (HEART BURN)	☐ YES	☐ NO	PACEMAKER	☐ YES	☐ NO	_____	☐ YES	☐ NO

FAMILY MEDICAL HISTORY

	MOTHER (AGE: ___)	FATHER (AGE: ___)	SIBLINGS (AGE: ___)
HEART DISEASE			
HYPERTENSION			
STROKE			
CANCER			
DIABETES			
KIDNEY DISEASE			
MENTAL ILLNESS			
HIGH CHOLESTEROL			
OTHER			
IF DECEASED, AGE OF DEATH:			

PROCEDURES

	PROCEDURE / DATE	PROCEDURE / DATE
SURGERIES:		
HOSPITALIZATIONS:		
INVASIVE (HEART PROCEDURES): I.E. CARDIAC CATH, ANGIOPLASTY, STENTS, OPEN HEART SURGERY		
NON-INVASIVE (HEART PROCEDURES): I.E. ECHOCARDIOGRAM, CAROTID US, AORTIC US, STRESS ECHO, EKG, HOLTER MONITOR, NUCLEAR STRESS TEST		

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

REVIEW OF SYSTEMS

INSTRUCTIONS: CHECK YES OR NO TO THE FOLLOWING QUESTIONS IF YOU HAVE HAD THESE SYMPTOMS IN THE LAST 6 MONTHS

GENERAL:	**YES**	**NO**	**COMMENTS**
Decreased exercise tolerance?	☐	☐	
Fatigue?	☐	☐	
Weight Change? Gain ☐ Loss ☐ How Much? _____ Period of time? _____	☐	☐	
Change in Appetite?	☐	☐	
EYES:	**YES**	**NO**	**COMMENTS**
Do you wear glasses?	☐	☐	
Do you have blurred vision?	☐	☐	
Do you experience double vision?	☐	☐	
Have you experienced visual field loss?	☐	☐	
EARS, NOSE AND THROAT:	**YES**	**NO**	**COMMENTS**
Do you have a hearing deficit?	☐	☐	
Dizziness with changing position?	☐	☐	
Chronic sinus problems?	☐	☐	
Do you have nosebleeds?	☐	☐	
Do you wear dentures	☐	☐	
Hoarseness / Change in voice?	☐	☐	
RESPIRATORY: (LUNGS)	**YES**	**NO**	**COMMENTS**
Do you have a chronic cough? ☐ Productive ☐ Dry?	☐	☐	
Have you coughed up blood?	☐	☐	
Do you have shortness of breath? ☐ at rest ☐ with activity?	☐	☐	
Do you wheeze?	☐	☐	
Do you snore?	☐	☐	
CARDIOVASCULAR: (HEART)	**YES**	**NO**	**COMMENTS**
Chest pain, pressure, or tightness? ☐ at rest ☐ with activity?	☐	☐	
Heart palpitations (racing)?	☐	☐	
Irregular heart beats?	☐	☐	
Short of breath lying flat?	☐	☐	How many pillows do you sleep on at night?
Waking up from sleep short of breath?	☐	☐	
Swelling of feet, ankles or legs?	☐	☐	
Pain in legs with walking?	☐	☐	Describe distance before pain develops:
Varicose veins?	☐	☐	
Non-healing sores on legs or feet?	☐	☐	

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

REVIEW OF SYSTEMS

INSTRUCTIONS: CHECK YES OR NO TO THE FOLLOWING QUESTIONS IF YOU HAVE HAD THESE SYMPTOMS IN THE LAST 6 MONTHS

GASTROINTESTINAL: (STOMACH)	**YES**	**NO**	**COMMENTS**
Frequent nausea?	☐	☐	
Frequent vomiting?	☐	☐	
Frequent diarrhea?	☐	☐	
Do you have problems with constipation?	☐	☐	
Blood in stool?	☐	☐	
GENITOURINARY: (URINARY)	**YES**	**NO**	**COMMENTS**
Do you have pain with urination?	☐	☐	
Blood in urine?	☐	☐	
Sense of urgency to urinate?	☐	☐	
Do you have any sexual dysfunction?	☐	☐	
Do you have a poor stream?	☐	☐	
MUSCULOSKELETAL: (BONES)	**YES**	**NO**	**COMMENTS**
Chronic back pain?	☐	☐	
Joint pain?	☐	☐	
Muscle pain?	☐	☐	
Muscle weakness?	☐	☐	
NEUROLOGICAL: (BRAIN)	**YES**	**NO**	**COMMENTS**
Temporary weakness of an arm or leg?	☐	☐	
Fainting or loss of consciousness?	☐	☐	
Severe Headaches?	☐	☐	
Numbness or tingling of an extremity?	☐	☐	
Any abnormalities in your sleep?	☐	☐	
PSYCHIATRIC: (MENTAL HEALTH)	**YES**	**NO**	**COMMENTS**
Are you suffering from symptoms of depression?	☐	☐	
Are you suffering from symptoms of anxiety?	☐	☐	
ENDOCRINE:	**YES**	**NO**	**COMMENTS**
Are you excessively thirsty?	☐	☐	
Do you have any temperature intolerances?	☐	☐	
HEMATOLOGICAL / IMMUNOLOGIC:	**YES**	**NO**	**COMMENTS**
Do you bleed or bruise easily?	☐	☐	
INTEGUMENT: (SKIN)	**YES**	**NO**	**COMMENTS**
Changes in moles?	☐	☐	
Rash?	☐	☐	
Itching?	☐	☐	
Changes in hair / nails?	☐	☐	

FLORIDA KEYS CARDIOLOGY

Madhavi Gunda Chunduru, MD, F.A.C.C.

Diplomate of the American Board of Internal Medicine & Cardiovascular Diseases / Fellow of the American College of Cardiology

Mailing Address: P.O. Box 9507 Tavernier, FL 33070 | **Phone:** (305)853-7171 | **Fax:** (305)853-7151

PHYSICAL EXAMINATION

Left Arm

BP _____ / _____ mmHg (SITTING)

Right Arm

BP _____ / _____ mmHg (SITTING)

Pulse _____ / Min (SITTING)

Respiratory Rate _____ /Min

Temperature _____ °C ☐ Oral

Left Arm / Leg

BP _____ / _____ mmHg (SUPINE OR STANDING)

Right Arm / Leg

BP _____ / _____ mmHg (SUPINE OR STANDING)

Pulse _____/ Min (SUPINE OR STANDING)

Height _____ BMI _____

Weight _____ ABI _____

GENERAL APPEARANCE

☐NL ☐ABNL

Describe Abnormalities:

EYES

☐NL ☐ABNL CONJUNCTIVA / SCLERA / LIDS

Describe Abnormalities:

EARS, NOSE, MOUTH, THROAT

☐NL ☐ABNL TEETH, GUMS AND PALATE

☐NL ☐ABNL ORAL MUCOSA

Describe Abnormalities:

NECK

☐NL ☐ABNL THYROID

☐NL ☐ABNL JUGULAR VEINS

☐NL ☐ABNL CAROTID ARTERIES

Describe Abnormalities:

RESPIRATORY

☐NL ☐ABNL RESPIRATORY EFFORT

☐NL ☐ABNL AUSCULTATION OF LUNGS

Describe Abnormalities:

NEUROLOGICAL / PSYCHIATRIC

☐NL ☐ABNL ALERT AND ORIENTED X3

☐NL ☐ABNL MOOD AND AFFECT

☐NL ☐ABNL FOCAL SENSORY, MOTOR SKILLS

Describe Abnormalities:

	RIGHT		LEFT	
CAROTID		B	B	
AORTA	PALPABLE Normal			B
FEMORAL		B	B	
PEDAL		B	B	

CARDIOVASCULAR

☐NL ☐ABNL 1ST AND 2ND HEART SOUNDS

☐NL ☐ABNL GALLOP S3

☐NL ☐ABNL GALLOP S4

☐NL ☐ABNL ___ / VI SYSTOLIC MURMUR @ _____

☐NL ☐ABNL ___ / IV DIASTOLIC MURMUR @ _____

Describe Abnormalities:

GASTROINTESTINAL

☐NL ☐ABNL ABDOMINAL EXAM

☐NL ☐ABNL LIVER AND SPLEEN

☐NL ☐ABNL ABDOMINAL WALL (e.g. hernia)

Describe Abnormalities:

MUSCULOSKELETAL

☐NL ☐ABNL EXAM OF BACK

☐NL ☐ABNL GAIT

☐NL ☐ABNL MUSCLE STRENGTH AND TONE

Describe Abnormalities:

EXTREMITIES

☐NL ☐ABNL SKIN, DIGITS AND NAILS

☐NL ☐ABNL EDEMA PRESENT, GRADE ___

☐NL ☐ABNL PRETIBIAL HYPERPIGMENTATION

Describe Abnormalities:

SKIN

☐NL ☐ABNL RASH

☐NL ☐ABNL ECCHYMOSES

Describe Abnormalities:

☐ VARICOSE VEINS ☐ YES ☐ NO

GRADING 0-4, 3 = NORMAL