Date of Admission: **Patient Name:** **Age:**

HISTORY

Chief Complaint:

History of Present Illness:
Start with one-liner. E.g. "2-year old admitted with a presumptive diagnosis of croup." Your one-liner should express what you think the diagnosis is.Then continue and give a supporting HPI with **pertinent positives** and end with **pertinent negatives. OPQRST-A** for each major symptom.

Past Medical History:

Past Surgical History:

Family History: Non-contributory

Social History: (Birth place; Education; Job/work; Religion; Marriage/Divorce; Living accommodations; persons at home, Diet, Exercise, hobbies. Smoking, Alcohol, Drugs)

Medications:

Allergies: NKDA

Immunizations:

Review of Systems: All 10 systems reviewed negative except as stated in HPI

PHYSICAL EXAMINATION

Vital Signs:

Gen: NAD, AOx3, well developed, well-nourished.
HEENT:
Neck: Supple
CVS: Normal S1 S2, RRR, no M/R/G
Lungs: CTAB, no W/R/R
Abdomen: Soft NT ND good BS, No HSMG
Rectal:
Skin: No rashes or lesions
Musculoskeletal:
Neurologic: CN, sensation, strength, reflexes, cerebellum, gait

Laboratory Data:

Imaging Studies:

ASSESSMENT / PLAN
____ year old M / F with….

1. Pyelonephritis
Status:
Newly dx, tx started in the ED.
Plan:
Cont. tx with cefotaxime 50mg/kgq 6 hours
Urine culture added to UA this AM, follow up on result
RUS
VCUG pending RUS results
Continue IVF till PO improves
Tylenol prn fever
Add Bcx if not in lab (will follow up)
CRP in AM

2. _____
Status:

Plan: