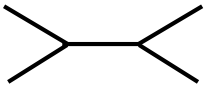
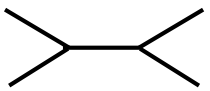
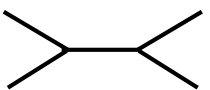
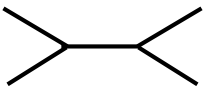


Name:

Age: (M/F) RM #:

ALL:

CC: HPI:		PROBLEM LIST	MEDS
		1.	1.
		2.	2.
		3.	3.
		4.	4.
		5.	5.
		6.	6.
		7.	7.
		8.	8.
		9.	9.
		10.	10.
		11.	11.
		12.	12.
		13.	13.
		14.	14.
		15.	15.
PMH / PSH / FH	Home Meds:		

<input type="text" value="/"/>	Tm	HR	R	BP	O2Sat	I/O	<input type="text" value="/"/>	<input type="checkbox"/>
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PMD/Consults: