Appendicitis Test

Patient Information:

Name:

Age: **Sex:** **Date of Birth:**

Patient ID:

Date of Evaluation:

Referring Physician:

Clinical History:

- **Presenting Symptoms:**
  - Abdominal Pain (Yes / No):
    - Location:
    - Onset:
    - Character:
    - Radiation:
    - Associated Symptoms:
  - Nausea (Yes / No):
  - Vomiting (Yes / No):
  - Fever (Yes / No):
  - Loss of Appetite (Yes / No):
  - Other:

Physical Examination:

- **Vital Signs:**
  - Temperature:
  - Heart Rate:
  - Blood Pressure:
  - Respiratory Rate:
- **Abdominal Examination:**
  - Tenderness (Yes / No):
    - Location:
  - Rebound Tenderness (Yes / No):
  - Rovsing's Sign (Positive / Negative):

- Psoas Sign (Positive / Negative):
- Obturator Sign (Positive / Negative):
- Guarding (Yes / No):
- Rigidity (Yes / No):

Laboratory Tests:

- **Complete Blood Count (CBC):**
  - White Blood Cell Count:
  - Hemoglobin:
  - Hematocrit:
  - Platelet Count:
- **C-Reactive Protein (CRP):**
- **Urinalysis:**
  - Leukocytes:
  - Nitrite:
  - Other:

Imaging Studies:

- **Abdominal Ultrasound:**
  - Findings:

- **Computed Tomography (CT) Scan:**
  - Findings:

Diagnosis:

- **Clinical Assessment:**
- **Differential Diagnosis:**

Comments:

Recommendations:

- **Management Plan:**

- **Surgical Consultation** (Required / Not Required):
- **Follow-up:**

Physician's Signature:

- **Name:**
- **Signature:**
- **Date:**

Remember, this template is illustrative and should be modified to fit the specific procedures and requirements of the healthcare institution. A qualified healthcare professional must fill out the content based on actual patient data and clinical findings.