

Medical Surgical

Patient Information

Name: _____

Date of Birth: _____

Medical Record Number: _____

Admission Date: _____

Allergies: _____

Current Medications:

Medical History

Chronic Conditions:

Previous Hospitalizations: _____

Allergies/Reactions: _____

Current Health Status: _____

Surgical History

Previous Surgeries (include dates): _____

Complications/Outcomes: _____

Post-Surgical Considerations: _____

Vital Signs

Heart Rate: _____

Blood Pressure: _____

Respiratory Rate: _____

Temperature: _____

Physical Assessment

General Appearance: _____

Skin Condition: _____

Neurological Status: _____

Cardiovascular Status: _____

Respiratory Status: _____

Gastrointestinal Status: _____

Musculoskeletal Status: _____

Laboratory Results

Complete Blood Count (CBC): _____

Chemistry Panel:

Coagulation Studies: INR and PTT within normal limits: _____

Imaging Studies: _____

Other Diagnostic Tests: _____

Nursing Care Plans

Goals/Objectives:

Interventions:

Medications and Administration

Monitoring Requirements:

Patient Education:

Progress Notes

Date/Time: _____

Summary of Patient's Condition:

Response to Treatment:

Changes in Vital Signs:

New Developments/Issues:

Plan for Next Steps:

Review and Approval

Physician Signature: Dr. Jane Smith

Nursing Signature: RN, Sarah Johnson

Allied Health Professional Signature:

Storage and Retrieval

Save in Electronic Health Record: _____

Organize for Easy Retrieval: _____