

PHYSICIAN SUPPLEMENTAL RECORD

ABDOMINAL PAIN

PATIENT'S NAME: _____ DATE: _____ AGE: _____ SEX: M / F

VITAL SIGNS: A1 BP _____ A3 P _____ A4 R _____ A5 T _____ A6 HT _____ []Stated A7 WT _____ []Stated

CC5 TIME OF PAIN ONSET: _____ []sudden onset []gradual onset CC1 LOCATION OF PAIN: _____

CC2 CHARACTER OF PAIN: []sharp []dull []burning []pressure []crushing []tearing []squeezing []stabbing []cramping

RADIATION OF PAIN: []none []inguinal []chest []back []shoulder []arm []leg

CC3 SEVERITY: (0=none, 10=worse) _____ []constant []intermittent

CC7 PAIN MADE WORSE BY: []eating []exertion []breathing []supine

CC7 PAIN RELIEVED BY: []rest []sitting []medication []vomiting []bowel movement

INJURY: []No []Yes TIME OF INJURY: _____ HOW INJURED: []struck []fell []MVA.

FELL FROM: _____ TO: _____ A DISTANCE OF: _____

MEDICATIONS TAKEN: _____ ALLERGIES: _____

OBGYN: []LMP GR: P: AB: HISTORY OF: []PID []Sexually active []Sexually Transmitted Disease.

LAST MEAL AND TIME: _____ TIME OF LAST BOWEL MOVEMENT: _____ []normal []diarrhea []blood

ORTHOSTATIC: SUPINE BP: P: SITTING BP: P: STANDING BP: P:

<input type="checkbox"/> DYSURIA	<input type="checkbox"/> URINARY FREQUENCY	<input type="checkbox"/> HEMATURIA	<input type="checkbox"/> DIARRHEA
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> VOMITING	<input type="checkbox"/> BLOOD IN STOOLS
<input type="checkbox"/> WEIGHT LOSS / GAIN	<input type="checkbox"/> VAGINAL BLEEDING	<input type="checkbox"/> PAIN WITH EATING	<input type="checkbox"/> EYE DISCOLORATION
<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> FEVER	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> SHORTNESS OF BREATH
<input type="checkbox"/> COUGH	<input type="checkbox"/> CONGESTION	<input type="checkbox"/> SYNCOPE	<input type="checkbox"/> PAIN WITH MOVEMENT
<input type="checkbox"/> PAIN WITH COUGH	<input type="checkbox"/> PAIN WITH BREATHING	<input type="checkbox"/> PAIN AT REST	<input type="checkbox"/> PAIN WITH EATING
<input type="checkbox"/> ALCOHOL USE	<input type="checkbox"/> SMOKING	<input type="checkbox"/> TRAVEL/CAMPING	<input type="checkbox"/> BACK / FLANK PAIN

PAST HISTORY:

<input type="checkbox"/> ULCER DISEASE	<input type="checkbox"/> BOWEL DISEASE	<input type="checkbox"/> COLITIS	<input type="checkbox"/> GB DISEASE
<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> RENAL STONE	<input type="checkbox"/> SICKLE CELL DISEASE	<input type="checkbox"/> OVARIAN CYST
<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> DIABETES	<input type="checkbox"/> OBESITY	<input type="checkbox"/> PNEUMONIA
<input type="checkbox"/> HIATAL HERNIA	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> MYOCARDIAL INFARCT	<input type="checkbox"/> DIVERTICULA DISEASE

SURGERY: []APPENDECTOMY []CHOLECYSTECTOMY []HYSTERECTOMY []TUBAL LIGATION []OTHER: _____

[]PELVIC EXAM: []NEGATIVE []POSITIVE FINDINGS: _____

[]RECTAL EXAM: []NEGATIVE []POSITIVE FINDINGS: _____

[]STOOL GUAIAIC: []NEGATIVE []TRACE POSITIVE []STRONGLY POSITIVE COLOR OF STOOL: _____

[]PREGNANCY TEST: []NEGATIVE []POSITIVE

[]EKG: _____ READ BY []ED PHYSICIAN []CARDIOLOGIST []OTHER _____

[]CHEST X RAY: _____ READ BY []ED PHYSICIAN []RADIOLOGIST []OTHER _____

[]ABDOMEN X RAY: _____ READ BY []ED PHYSICIAN []RADIOLOGIST []OTHER _____

[]ABDOMEN ULTRASOUND: _____ READ BY []ED PHYSICIAN []RADIOLOGIST []OTHER _____

[]PELVIC ULTRASOUND: _____ READ BY []ED PHYSICIAN []RADIOLOGIST []OTHER _____

DIFFERENTIAL DIAGNOSIS AND/OR HIGH RISKS:

Gallstones, Cholecystitis, Renal stones, UTI, Urinary obstruction, Ovarian cyst, Pancreatitis, Appendicitis, Ectopic pregnancy, Adhesions, Pelvic inflammatory disease, Endometriosis, Back pain, Ulcer disease, Gastritis, Esophagitis, Diverticulitis, Colitis, GI obstruction, Gastroenteritis, Aortic aneurysm, GI perforation, GI bleeding, Trauma, Peritonitis, Pregnancy.

NOTES

Print Physician's Name

Physician's Signature

Date