5.Physical Examination continued (Pertinent Findings per System)

CHEST/LUNGS	☑ Essentially normal	☐ Asymmetrical chest expansion	☐ Decreased breath sounds	☐ Wheezes
	☐ Lumps over breast(s)	☐ Rales/Crackles/Rhonchi	☐ Intercostal rib retraction	
	Others:			
CVS	☑ Essentially normal	☐ Displaced apex beat	☐ Heaves and/or thrills	☐ Pericardial bulge
	☐ Irregular rhythm	☐ Muffled heart sounds	☐ Murmur	
	Others:			
ABDOMEN	☑ Essentially normal	☐ Abdominal rigidity	☐ Abdominal tenderness	☐ Hyperactive bowel sounds
	☐ Palpable mass(es)	☐ Tympanitic/dull abdomen	☐ Uterine contraction	
	Others:			
GU(IE)	☑ Essentially normal	☐ Blood stained in exam finger	☐ Cervical Dilatation	☐ Presence of abnormal discharge
	Others:			
SKIN/EXTREMITIES	☑ Essentially normal	☐ Clubbing	☐ Cold clammy skin	☐ Cyanosis/mottled skin
	☐ Edema / Swelling	☐ Decreased mobility	☐ Pale nailbeds	☐ Poor skin turgor
	☐ Rashers/Petechiae	☐ Weak pulses		
	Others:			
NEURO-EXAM	☑ Essentially normal	☐ Abnormal gait	☐ Abnormal position sense	☐ Abnormal/decreased sensation
	☐ Abnormal reflex(es)	☐ Poor/altered memory	☐ Poor muscle tone/strength	☐ Poor coordination
	Others:			

IV. COURSE IN THE WARD (Attach photocopy of laboratory/imaging results) ☐ Check box if there is/are additional sheet(s)

Date	DOCTOR'S ORDER/ACTION
04-21-2025	HEMO SESSION

3. SURGICAL PROCEDURE / RVS CODE (Attach of CTC of OR techniques):
HEMODIALYSIS N/A 90935

V. DRUGS/MEDICINES ☐ Check box if there is/are additional sheet(s)

Generic name	Quantity/Frequency/Dosage/Route	Total Cost	Generic name	Quantity/Frequency/Dosage/Route(cont)	Total Cost(cont)
BIOGESIC	1, , 2 TABS TWICE A DAY , TABLET	Php10.00 (P10.00 x 1)			

VI. OUTCOME OF TREATMENT

☑ **IMPROVED** ☐ HAMA ☐ EXPIRED ☐ ABSCONDED ☐ TRANSFERRED Specify reason: _____

VII. CERTIFICATION OF HEALTH CARE PROFESSIONAL

Certification of Attending Health Care Professional:

I certify that the above information given in this form, including in all attached laboratory and imaging results are true and correct.

LIFE G. ON
Signature over Printed Name of Attending Health Care Professional

0 4 - 1 6 - 2 0 2 5
month day year
Date Signed