Medical Care Report Form

Subjective

Name ______________________________ Age ________ Gender ________

Description of Person: ______________________________

____

What Happened? ______________________________

____

Chief Complaint: ______________________________

SAMPLE History

Symptoms ______________________________

Allergies ______________________________

Medications ______________________________

Past Medical History ______________________________

Last Input and Output ______________________________

Events Leading To ______________________________

Objective

Physical Exam

Head ______________________________

Neck ______________________________

Shoulders/Chest ______________________________

Abdomen/Pelvis ______________________________

Legs/Arms ______________________________

Back ______________________________

Vital Signs

Time	LOR	Orientation	Pulse	Respiration	Tissue/Skin		
________	☐ Alert ☐ Verbal ☐ Physical ☐ Unresponsive	☐ Person ☐ Place ☐ Time ☐ Event	________ ☐ Weak ☐ Strong ☐ Regular ☐ Irregular	________ ☐ Deep ☐ Shallow	☐ Pink ☐ Pale ☐ Blue ☐ Red	☐ Warm ☐ Cold ☐ Hot	☐ Dry ☐ Warm

Time	LOR	Orientation	Pulse	Respiration	Tissue/Skin		
________	☐ Alert ☐ Verbal ☐ Physical ☐ Unresponsive	☐ Person ☐ Place ☐ Time ☐ Event	________ ☐ Weak ☐ Strong ☐ Regular ☐ Irregular	________ ☐ Deep ☐ Shallow	☐ Pink ☐ Pale ☐ Blue ☐ Red	☐ Warm ☐ Cold ☐ Hot	☐ Dry ☐ Warm

Time	LOR	Orientation	Pulse	Respiration	Tissue/Skin		
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PRN3151 (3/18)

Assessment

Suspected Problems

Developing Problems

Plan

Initial Treatments

Evacuation Decision ☐ No Evacuation ☐ Go Fast ☐ Go Slow

Extended Treatments