



Patient: test, test **DOB:** n/a **Call Date:** 04/05/2009

Patient Complaint

Primary Complaint Narrative <input type="text"/>	Duration of Primary Complaint <input type="text"/>	Time Units of Duration <input type="text"/>
Secondary Complaint Narrative <input type="text"/>	Anatomic Location <input type="text"/>	Organ System <input type="text"/>
	Duration of Secondary Complaint <input type="text"/>	Time Units of Duration <input type="text"/>

Impressions

Primary Symptom <input type="text"/>	Other Symptoms	<input type="checkbox"/> Malaise <input type="checkbox"/> Mass/Lesion <input type="checkbox"/> Mental/Psych <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> None <input type="checkbox"/> Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rash/Itching <input type="checkbox"/> Swelling	<input type="checkbox"/> Transport Only <input type="checkbox"/> Weakness <input type="checkbox"/> Wound <input type="checkbox"/> Not Applicable <input type="checkbox"/> Not Recorded <input type="checkbox"/> Not Reporting <input type="checkbox"/> Not Known <input type="checkbox"/> Not Available
Primary Impression <input type="text"/>	Secondary Impression <input type="text"/>		
Barriers to Patient Care <input type="text" value="Developmentally Impaired"/> <input type="text" value="Hearing Impaired"/> <input type="text" value="Language"/> <input type="text" value="None"/> <input type="text" value="Physically Impaired"/> <input type="button" value="Clear Selected"/>	Alcohol/Drug Use Indicators <input type="text" value="Smell of Alcohol on Breath"/> <input type="text" value="Patient Admits to Alcohol Use"/> <input type="text" value="Patient Admits to Drug Use"/> <input type="text" value="Alcohol and/or Drug Paraphernalia at Scene"/> <input type="text" value="Not Applicable"/> <input type="button" value="Clear Selected"/>	Pregnancy <input type="text"/>	