

## REGIONAL WRITE-UP—CARDIOVASCULAR SYSTEM

Date \_\_\_\_\_

**Examiner** \_\_\_\_\_

**Patient** \_\_\_\_\_ **Age** \_\_\_\_\_ **Gender** \_\_\_\_\_

Reason for visit \_\_\_\_\_

## I. Health History

	No	Yes, explain
1. Any <b>chest pain</b> or tightness?		
2. Any <b>shortness of breath</b> ?		
3. Use more than one pillow to sleep?		
4. Do you have a <b>cough</b> ?		
5. Do you seem to <b>tire easily</b> ?		
6. Facial skin ever turn blue or ashen?		
7. Any <b>swelling</b> of feet or legs?		
8. Awaken at night to urinate?		
9. Any past history of heart disease?		
10. Any family history of heart disease?		
11. Assess cardiac risk factors:		

## II. Physical Examination

### A. Carotid arteries

### Inspect and palpate

Grade R \_\_\_\_\_ L \_\_\_\_\_

(0 = absent, 1+ weak, 2+ normal, 3+ increased, 4+ bounding)

### B. Jugular venous system

External jugular veins (circle one):  $\left\{ \begin{array}{l} \text{collapsed supine} \\ \text{meniscus visible at } \underline{\hspace{2cm}} \text{ bed elevated} \end{array} \right.$

Internal jugular venous pulsations  $\begin{cases} \text{not visible} \\ \text{visible at } \underline{\hspace{2cm}} \text{ bed elevated} \end{cases}$   
(circle one):

### C. Precordium

### Inspect and palpate

1. Skin color and condition \_\_\_\_\_
2. Chest wall pulsations \_\_\_\_\_
3. Heave or lift \_\_\_\_\_
4. Apical impulse in the \_\_\_\_\_ at \_\_\_\_\_  
Size \_\_\_\_\_ Amplitude \_\_\_\_\_

### D. Auscultation

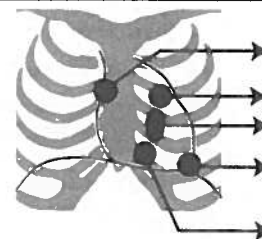
1. Identify anatomic areas where you will listen.
2. Rate and rhythm \_\_\_\_\_
3. Identify S<sub>1</sub> and S<sub>2</sub> in diagram at right and note any variation.

Fill in any murmur below:

$$S_1 \quad S_2 \quad S_1 \quad S_2$$

S<sub>1</sub> \_\_\_\_\_

S<sub>2</sub> \_\_\_\_\_



## 4. Listen in systole and diastole:

Extra heart sounds \_\_\_\_\_  
Systolic murmur \_\_\_\_\_  
Diastolic murmur \_\_\_\_\_

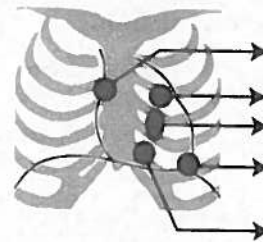
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Summarize your findings using the SOAP format.

**Subjective** (Reason for seeking care, health history)

**Objective** (Physical examination findings)

Record findings using diagram



**Assessment** (Assessment of health state or problem, diagnosis)

**Plan** (Diagnostic evaluation, follow-up care, patient teaching)