

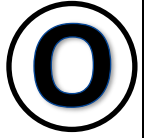
แบบบันทึกการตรวจร่างกายโดยแพทย์ [PHYSICAL EXAMINATION] [update 19/10/2562]

Date _____ / _____ / _____ Time _____.

Vital sign (เกณฑ์ 1) : BT _____ °C, PR _____ bpm, RR _____ /min, BP _____ / _____ (อายุ > 3 ปี)

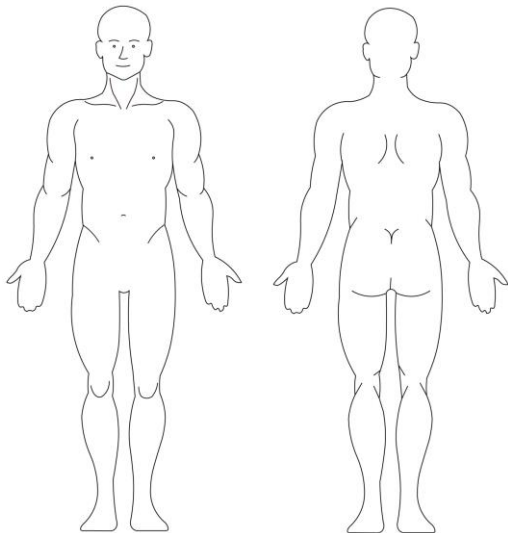
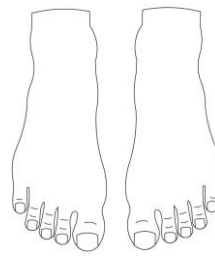
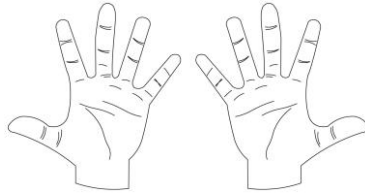
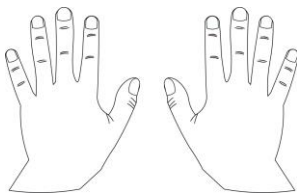
WT HT (เกณฑ์ 2) : BW _____ kgs., Height _____ cms., BMI _____, BSA _____.

PE (เกณฑ์ 3,5) : {ดู คำ เาะ พัง}



| System | Normal | Abnormal | Note |
|------------------|--------------------------|--------------------------|--|
| GA | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| HEENT | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Cardiovascular | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Respiratory | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Gastrointestinal | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Genitourinary | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Musculoskeleton | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Neurologic | <input type="checkbox"/> | <input type="checkbox"/> | Conscious _____ E _____ V _____ M _____ Pupil Rt _____ mm., Lt _____ mm. _____. |
| Psychiatric | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | _____. |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | _____. |

วาดรูป หรือ กราฟิก (เกณฑ์ 4) :



Problem list (เกณฑ์ 6) 1 _____.



2 _____.
3 _____.
4 _____.

CLINICAL RISK _____

Provisional diagnosis(เกณฑ์ 7) : _____

Observe Investigation Treatment Isolation



Plan (เกณฑ์ 8) 1 _____.

2 _____.

3 _____.

(เกณฑ์ 9) ลงนามแพทย์ : _____

(_____)

| | | | |
|-----------------------|------|-----------|---------------------|
| Name of Patient | Age | HN. | AN. |
| Department or Service | Ward | Diagnosis | Attending Physician |