

## TELEHEALTH EXAM

Patient:	DOB:	AGE:	Today's Date:
Allergies:			
Medications (attach list if needed):			
<input type="checkbox"/> Medication list attached			
Pharmacy:	Lab/Hospital:	PCP:	
Height:     '     "	Weight:     lbs.	Length:     cm	Weight:     g/kg (please specify)
LPM:			
Chief Complaint/Appt. Reason:			
Vitals:			
Heart Rate:		Respiratory Rate:	
Blood Pressure:		Temperature:	
SaO2:			
Specialty Vitals:			
Walking Pulse Oximetry			
Resting SaO2:		Pulse:	
SaO2 AFTER walking 300':		Pulse:	
SaO2 AFTER 1 minute of rest:		Pulse:	
Peak Flow Reading		Reading 1:	
		Reading 2:	
		Reading 3:	
Orthostatic Blood Pressures	Blood Pressure AFTER lying down for 5 minutes:		Pulse:
	Blood Pressure AFTER standing for 1 minute:		Pulse:
	Blood Pressure AFTER standing for 3 minutes:		Pulse:
Additional Information:			
Immunizations up to date:		Refills Needed: <input type="checkbox"/> yes <input type="checkbox"/> no	

### Risk Factors Reviewed:

Diet

Exercise:

Cigarette/Tobacco use:    yes    no

Pack per Day:

Alcohol use:    yes    no

Average Drinks per Week:

Illicit Drug Use:    yes    no

Contraceptive Use:

Misc.: