Medical _____ Dental _____ Both _____

Date: _____ Clinic Location: _____ MR #: _____

Last Name: _____ First Name: _____ DOB:_____

Have you traveled outside the US in the past three (3) weeks? Yes ____ No ____ Male □ Female

Triage Documentation

ALLERGIES: ☐ NKDA	LMP:
MEDICATIONS:	
CHIEF COMPLAINT:	
HISTORY OF MEDICAL CONDITIONS:	

Family Doctor _____

PAIN: ☐ Yes ☐ No Location: _____ How long: _____ Intensity (WBN: 0-10)_____
☐ Non-Radiating ☐ Radiating _____ Description: ☐Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ _____
Occurs: ☐Ambulating ☐ Resting ☐ Eating ☐Exercising Relieved by: _____ Worsens: _____

NEURO: Orientation: ☐ x4 ☐ Person ☐ Place ☐ Time ☐ Situation ☐ Dementia ☐ Decreased LOC ☐ _____

AIRWAY: ☐ Breathing WNL ☐ Clear ☐ Obstructed ☐SOB: ☐Resting ☐On Exertion ☐_____
Cough: ☐ Yes ☐ No ☐ Nonproductive ☐ Productive Color: _____ Amount: _____ How Long: _____

CARDIO: ☐No Symptoms ☐ Edema:☐ Pitting ☐ Non-pitting ☐1^+ ☐2^+ ☐3^+ ☐4^+ ☐ _____ Location: _____

SKIN: ☐ Warm/Dry ☐ Hot ☐ Cool ☐ Cold ☐ Clammy ☐ Diaphoretic ☐ Pale ☐ Rash: Location _____
Size: _____ Source:_____☐ Wounds: Location: _____Size: _____Source: _____
☐ Drainage: Location: _____ Amount/Consistency: _____ Color: _____ Odor: ☐Yes ☐ No

GU: ☐ WNL ☐ Burning ☐ Blood How Long: _____ Frequency: _____ Voids: ☐ Normal ☐ Small

GI: ☐ WNL ☐ Constipation ☐ Diarrhea How Long: _____ Frequency: _____

ADDITIONAL NOTES:

Weight: _____lbs / kg ☐ Verbal ☐ Scale Height: ____Inches / Centimeters / Estimate ☐ Verbal ☐ Measured

TIME	TEMPERATURE	ROUTE	PULSE	BLOOD PRESSURE	RESPIRATIONS
__:__				/	

Triage Staff: _____ Interpreter: _____