

Respiratory System

Name: _____

Date: _____

Age: _____ Gender: _____

History

Review of the respiratory system:

YES/NO	If YES, provide details:
<input type="checkbox"/> <input type="checkbox"/>	Allergies _____
<input type="checkbox"/> <input type="checkbox"/>	Fever _____
<input type="checkbox"/> <input type="checkbox"/>	Asthma, wheezing _____
<input type="checkbox"/> <input type="checkbox"/>	Tobacco use _____
<input type="checkbox"/> <input type="checkbox"/>	Medications _____
<input type="checkbox"/> <input type="checkbox"/>	Cough _____
<input type="checkbox"/> <input type="checkbox"/>	Sputum production _____
<input type="checkbox"/> <input type="checkbox"/>	Hemoptysis _____
<input type="checkbox"/> <input type="checkbox"/>	Chest pain _____
<input type="checkbox"/> <input type="checkbox"/>	Shortness of breath _____
<input type="checkbox"/> <input type="checkbox"/>	Occupational risk factors _____
<input type="checkbox"/> <input type="checkbox"/>	Environmental risk factors _____
<input type="checkbox"/> <input type="checkbox"/>	Respiratory disease history _____
<input type="checkbox"/> <input type="checkbox"/>	Use of aerosols or inhalants _____

Social history (occupational and home exposures, fitness activities, safety habits (i.e., seat belts, etc.):

Family history related to respiratory system:

Focused symptom analysis of current problem:

Problem statement: _____

Characteristics: _____

Onset: _____

Duration: _____

Location: _____

Severity: _____

Associated problems: _____

Efforts to treat: _____

Physical Assessment

Vital Signs

Temperature: _____ Pulse: _____

Respirations (rate, rhythm, quality): _____

Blood pressure: _____

Inspection

Skin (color, tone, texture): _____

Thorax (shape, symmetry, movement, use of accessory muscles): _____

Breathing (rate, pattern, audible sounds): _____

Posture: _____

Alertness: _____

Nails (oxygenation, clubbing): _____

Palpation

Skin (temperature, tenderness, unusual sensations): _____

Trachea (position, mobility): _____

Thoracic excursion (symmetry, anterior/posterior): _____

Tactile fremitus (characteristics): _____

Ribs and thorax: (shape, symmetry, tenderness, masses): _____

Respiratory excursion (findings): _____

Percussion

Tones over thorax (describe tones and location):

Describe: _____

Anterior: _____

Posterior: _____

Auscultation

Breath sounds (apices, anterior lungs, posterior lungs, lateral lung fields — anterior/posterior):

Respiratory sounds in each location:

Describe: _____

Anterior: _____

Posterior _____

Adventitious sounds (if present, describe): _____

Vocal Resonance (sound characteristics): _____

Analysis:
