AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	ELECTROCARDIOGRAPHIC RECORD	PREVIOUS ECG ☐ YES ☐ NO

CLINCIAL IMPRESSION	MEDICATION	☐ EMERGENCY ☐ ROUTINE	☐ BEDSIDE ☐ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B.P.	SIGNATURE OF WARD PHYSICIAN	DATE
						LEIGH McGRAW, MAJ, AN, FNP	

RHYTHM	AXIS DEVIATION (QRS)	RATES AURIC. VENT.

INTERVALS PR QRS QT	P WAVES

QRS COMPLEXES

RS-T SEGMENT	T WAVES

UNIPOLAR EXTREMITY LEADS *(Specify)*

PRECORDIAL LEADS *(Specify)*

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS

(Continue on reverse)

NO. ECG	SIGNATURE OF PHYSICIAN	PATIENT'S IDENTIFICATION NO.	DATE

PATIENT'S IDENTIFICATION *(For typed or written entires give: Name-last, first, middle; grade; date; hospital or medical facility.)*

REGISTER NO.	WARD NO.
BHBA	PHYS EXAM

NAME_____

SSN_____ RANK_____

ELECTROCARDIOGRAPHIC RECORD
(Attach Tracings to SF 507)
Medical Record

OPTIONAL FORM 520 (12-94)
GSA/ICMR, FIRMR

*U.S. GPO: 2001-472-148/40215