

MEDICAL RECORD		ELECTROCARDIOGRAPHIC RECORD				PREVIOUS ECG		
CLINICAL IMPRESSION					MEDICATION		<input type="checkbox"/> YES	<input type="checkbox"/> NO
							<input type="checkbox"/> EMERGENCY	<input type="checkbox"/> BEDSIDE
AGE SEX HEIGHT WEIGHT B.P.					SIGNATURE OF WARD PHYSICIAN		<input type="checkbox"/> ROUTINE	<input type="checkbox"/> AMBULANT
							DATE	
RHYTHM					AXIS DEVIATION (QRS)		RATES	
INTERVALS					P WAVES		AURIC. VENT.	
PR		QRS		QT				
QRS COMPLEXES								
R-ST SEGMENT					T WAVES			
UNIPOLAR EXTREMITY LEADS <i>(Specify)</i>								

PRECORDIAL LEADS *(Specify)*

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS

(Continue on reverse)

NO.		SIGNATURE OF PHYSICIAN				DATE
ECG		SPONSOR'S NAME				SPONSOR'S ID NUMBER
RELATIONSHIP TO SPONSOR		LAST	FIRST	MI	<i>(SSN or Other)</i>	
DEPART./SERVICE			HOSPITAL OR MEDICAL FACILITY		RECORDS MAINTAINED AT	
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)</i>					REGISTER NO.	
					WARD NO.	

ELECTROCARDIOGRAPHIC RECORD
(Attach Tracings to SF 507)
Medical Record