MACOMB

ALLERGIC TO:

PATIENT RECORD

Name: ______________________ Age: ____ M / F DOB: ______________ Date/Time: __________

Vitals: T P R BP Wt. Ht. LMP

Allergies: ______________________

C/C: ______________________

HX: ______________________

PX: ______________________

IMP: ______________________

Plan: ______________________

Patient verbalizes understanding of treatment plan ❑

Physician Signature Date/Time/

❑ X-rays:

❑ Lab In

❑ Lab Out

❑ Diagnostics

❑ PFT

❑ US

❑ EKG

❑ Injections

❑ Referral

❑ Other:

EVALUATION AND MANAGEMENT PRIMARY CARE CLINICS

(Level 1, 2 and 3 only and Intern/Resident has completed more than 6 months of training.)

I reviewed the history, physicial examination, diagnosis and plan with the intern/resident and concur with any amendments as necessary.

Comments:

Teaching Physician Signature Date/Time

Form #1

MO-315 (12/16)