McLaren Flint
FLINT, MICHIGAN 48532

Date _____

HISTORY & PHYSICAL

Patient _____ Physician _____

Chief Complaint _____

HISTORY
Present Illness _____

_____

_____

_____

_____

Allergies _____

Current Medications _____

_____

Past Medical History (check √ if present) or ☐ None

- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Myocardial Infarction
  Date: _____
- ☐ Irregular Heart Beat
- ☐ Pacemaker/ICD

Heart Failure:
- ☐ Systolic
- ☐ Diastolic

- ☐ Valvular Heart Disease
- ☐ Chronic Respiratory Failure

- ☐ COPD
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Peripheral Vascular Disease
- ☐ CVA
- ☐ Transient Ischemic Attack
- ☐ Seizures

Diabetes Mellitus:
- ☐ Type I
- ☐ Type II

Thyroid:
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

- ☐ Cancer
  (Type) _____
- ☐ Bleeding Disorders

_____ Pregnancies
_____ Deliveries

Chronic Kidney Disease Stages:
- ☐ Stage I – GFR > 90 with proteinuria
- ☐ Stage II – GFR 60-89
- ☐ Stage III – GFR 30-59
- ☐ Stage IV – GFR 15-29
- ☐ Stage V – GFR < 15 or dialysis
- ☐ ESRD

- ☐ Obesity
- ☐ Underweight
- ☐ Anemia
- ☐ Other _____

Past Surgical History _____

_____

Social History
- ☐ Occupation _____
- ☐ Smoking _____
- ☐ Drugs _____
- ☐ Alcohol _____
- ☐ Abuse (Psychosocial) _____

Family History
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Malignant Hyperthermia

Review of Systems (check √ if present) or ☐ None
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Fever/Chills
- ☐ Dizziness
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Visual Disturbance
- ☐ Hearing Problems
- ☐ Light-headedness
- ☐ Altered Bowel Habits
- ☐ Altered Bladder Habits
- ☐ Dyspepsia/Dysphagia
- ☐ Anorexia/Weight Loss
- ☐ Fatigue/Weakness
- ☐ Weakness in Extremities

PT.

MR.#/RM.

DR.

PHYSICAL (Explain any abnormalities under "Other"):

Vital Signs: ☐ Reviewed ☐ Other _____

HEENT: ☐ Normal ☐ Other _____

Neck: ☐ Normal ☐ Other _____

Breast: ☐ Normal ☐ N/A ☐ Other _____

Thorax: ☐ Normal ☐ Other _____

Heart: ☐ Normal ☐ Other _____

Lungs: ☐ Normal ☐ Other _____

Abdomen: ☐ Normal ☐ Other _____

Genitalia: ☐ Normal ☐ N/A ☐ Other _____

Pelvic: ☐ Normal ☐ N/A ☐ Other _____

Rectal: ☐ Normal ☐ N/A ☐ Other _____

Extremities: ☐ Normal ☐ Other _____

Neuro: ☐ Normal ☐ Other _____

Pertinent Labs & X-Rays:

_____

_____

_____

Provisional Diagnosis / Plan of Treatment:

_____

_____

_____

_____

_____

For Breast Patients only: Reconstructive Surgery Discussed ☐ Yes ☐ No

Date: _____ Time: _____Physician Signature _____

PT.

MR.#/RM.

DR.