

History and Physical 01	
Source of information	
Cc	
HPI	
PMH	
PSH	
ROS	
Meds	
Allerg	
Habits/Exposure	
Travel	
Immun	
Soc/Sex Hx	
Domestic Abuse	

Exam	
VS	Trunk, CVA
Mental status	Abd
HEENT	Ext
Neck	GU
Heart	Skin
Lungs	Neuro

Assessment
<i>Consider (not in order of importance):</i>
Abdomen/Nutrition
Baseline Functional Status
Cardiovascular
Derm/Devices
ENT
Fluid status
GU
Heme
Infection/Immunization
Joint/Muscle/Bone
Kidney
Lung
Metabolic (pH, lytes, endocrine)
Neuro/Psych/Pain
Onc
Plan for D/C



Admitting Orders
Admit to [attending], or Staff or MTS with attending
Dx
Diet
Aller
I & O
Fluid maintenance
Require meds, old & new
O2
Fever
GI reflux, nausea, constip
Pain
Anxiety/Agitation/Sleep
Abic?
Pulmonary
DVT prophylaxis
W/D prevention
Activity
Consult
Neuro and VS
Special labs
X-ray and special studies
Code status
Wound care
Old chart
Tubes

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Procedure Note 02


Patient name, reg
 Attending
 Date of dict
 Date of proc
 Name of procedure
 Primary procedurist,
 1st assist, 2nd assist
 Pre-proc dx
 Post-proc dx
 Description
 Patient cond

Transfer Orders

Transfer to...

Notify...
 [all physicians, attending
 and consultants]
 when patient arrives

Dx
 Diet
 I&O
 Act
 Go through other orders
 Labs
 Meds
 Tubes



INTERNAL MEDICINE

Discharge Summary 03

Your name
 Patient name and reg
 Day of dictation
 Patient admission date
 Patient discharge date
 Attending, service
 Admitting diagnoses
 Discharge diagnoses
 Brief admitting H & P,
 with pertinent studies
 Hosp course
 Consults/Proc's
 Discharge instructions
 Diet
 Activity
 Meds
 Follow-up
 Special instructions
 Condition

M-705 (7/13)

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