

McLaren Print System Order

Order No: 83467
 Order Date: 2024-02-27
 User: Andrea Miko
 Phone: 586-493-1605

Ship Location: McLaren Macomb Surgical Services
 1000 Harrington
 Mt Clemens, MI 48043

Forms

Quantity: 500
 Paragon Dept No: 24485
 Dept Name: Surgical Services
 Company Number: 260

Order Total Price: 25.75

Item Number: MAC-12 (226524)
 Item Description: History and Physical Form
 Revision Date: 10/2023
 Print: 1 sided black and white
 Paper: 60# Orange (Bright) Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Poster:
 Misc Info: 8.5x11 Black SS



HISTORY AND PHYSICAL

Name: _____

DOB: _____

Referring Physician: _____

CHIEF COMPLAINT: _____ DATE OF SURGERY: _____

OUTPATIENT SURGERY

<p>HISTORY & INDICATORS FOR PROCEDURES</p> <p>PAST MEDICAL HISTORY (CHECK IF APPLICABLE)</p> <p><input type="checkbox"/> No Significant Findings</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> COPD <input type="checkbox"/> Transient Ischemic Attack</p> <p><input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes Mellitus</p> <p><input type="checkbox"/> Abnormal Intestine <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Non-Insulin Dependent</p> <p><input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Rheum <input type="checkbox"/> Insulin Dependent</p> <p><input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Hepatitis <input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Blood Clots</p> <p><input type="checkbox"/> Psychotropic(s) <input type="checkbox"/> OVA <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> SEX: M Female Sex: _____ Other: _____</p> <p>CURRENT MEDICATIONS & DRUGS <input type="checkbox"/> NO MEDICATIONS TAKEN</p> <p><input type="checkbox"/> ALLERGENIC PROFILE (See to attached in this form)</p> <p>ALLERGENS OR MEDICATION REACTIONS <input type="checkbox"/> NONE KNOWN</p> <p>CLINICAL: _____</p> <p>PROSPECTIVE (IF APPLICABLE)</p> <p><input type="checkbox"/> SENSITIZATIONS UP TO DATE <input type="checkbox"/> SENSITIZATION STATUS UNKNOWN</p> <p>PAST SURGICAL HISTORY <input type="checkbox"/> NONE</p>	<p>DIAGNOSIS</p> <p>PLANNED PROCEDURE</p> <p style="text-align: center;">PHYSICAL EXAM</p> <p>VITAL SIGNS</p> <p>PULSE: _____ BP: _____ RR: _____ TEMP: _____</p> <p>HEIGHT: _____ HAIR: _____ WEIGHT: _____ HGT/POUNDS</p> <p style="text-align: center;">(SIGNIFICANT FINDINGS)</p> <p>CARDIOVASCULAR <input type="checkbox"/> NIL</p> <p>RESPIRATORY <input type="checkbox"/> NIL</p> <p>FAMILY HISTORY</p> <p>SOCIAL HISTORY</p> <p><input type="checkbox"/> Tobacco: _____</p> <p><input type="checkbox"/> Alcohol: _____</p> <p><input type="checkbox"/> Recreational: _____ <input type="checkbox"/> Drugs: _____</p> <p><input type="checkbox"/> Abuse: _____</p>
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DATE: _____ TIME: _____ PHYSICIAN SIGNATURE: _____

HISTORY & PHYSICAL UPDATE (REQUIRED IF HSP IS + 24 HRS OUT + 30 DAYS OLD — Completed Day of Procedure)

HSP re-evaluated, patient re-examined and NO change has occurred in the patient's condition since previous HSP was completed within the last 30 days.

A change HAS occurred in the patient's condition since previous HSP was completed within the last 30 days, noted below:

TIME: _____ DATE: _____ PHYSICIAN SIGNATURE: _____

Spec Info:

