

McLaren Print System Order

Order No: 84165
 Order Date: 2024-03-29
 User: Susan Brusati
 Phone: 586-323-4579

Ship Location: McLaren Macomb OPS Harrington Building
 21510 Harrington
 Clinton Township, Michigan 48036

Forms

Quantity: 100
 Paragon Dept No: 28500
 Dept Name: Outpatient Surgery Harrington Building-Suite 300
 Company Number: 260

Order Total Price: 3.85

Item Number: MAC-12 (226524)
 Item Description: History and Physical Form
 Revision Date: 10/2023
 Print: 1 sided black and white
 Paper: 20# Goldenrod Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Poster:
 Misc Info: 8.5x11 Black SS



Name: _____

DOB: _____

Referring Physician: _____

HISTORY AND PHYSICAL

CHIEF COMPLAINT: _____ DATE OF SURGERY: _____

OUTPATIENT SURGERY

<p>HISTORY & INDICATIONS FOR PROCEDURES</p> <p>PAST MEDICAL HISTORY (check or if pertinent & 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"/> Endocrine Metformin</p> <p><input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> New Health Dependent</p> <p><input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Reflex <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"/> Bleeder <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 <input type="checkbox"/> F <input type="checkbox"/> 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>DIET</p> <p>PROSTHESIS (if applicable)</p> <p><input type="checkbox"/> IMPLANTS OR UP TO DATE <input type="checkbox"/> BRANDED DEVICE UNKNOWN</p> <p>PAST SURGICAL HISTORY <input type="checkbox"/> NONE</p>	<p>DIAGNOSIS</p> <p>PLANNED PROCEDURE</p> <p>PHYSICAL EXAM</p> <p>VITAL SIGNS</p> <p>PULSE _____ BP _____ RR _____ TEMP _____</p> <p>HEIGHT _____ WEIGHT _____ HGT/WT _____</p> <p>CARDIOVASCULAR <input type="checkbox"/> WNL</p> <p>RESPIRATORY <input type="checkbox"/> WNL</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>
---	---

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

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

TIME: _____ DATE: _____ PHYSICIAN SIGNATURE: _____

Spec Info: Suite 300, 3rd Floor

