

McLaren Print System Order

Order No: 87209
 Order Date: 2024-07-25
 User: June Barrett
 Phone: (586)493-1605


Ship Location: McLaren Macomb
 1000 Harrington
 Mount .Clemens, , Michigan 48043

Forms

Quantity: 100
 Paragon Dept No: 28575
 Dept Name: Surgical Services
 Company Number: 260

Order Total Price: 4.48

Item Number: MAC-12 (226524)
 Item Description: History and Physical Form
 Revision Date: 10/2023
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Poster:
 Misc Info: 8.5x11 Black DS



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 present & 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"/> Abdominal Infection <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 Fee 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"/> SENSITIVITIES UP TO DATE <input type="checkbox"/> SENSITIVITIES UNKNOWN</p> <p>PAST SURGICAL HISTORY <input type="checkbox"/> NONE</p> <p>DATE: _____ TIME: _____ PHYSICIAN SIGNATURE: _____</p>	<p>DIAGNOSIS</p> <p>PLANNED PROCEDURE</p> <p>PHYSICAL EXAM</p> <p>VITAL SIGNS</p> <p>PULSE _____ BP _____ RR _____ TEMP _____</p> <p>HEIGHT _____ INCH WEIGHT _____ LBS HAIR/POUNDS _____</p> <p>CARDIOVASCULAR <input type="checkbox"/> NIL</p> <p>RESPIRATORY <input type="checkbox"/> NIL</p> <p>SIGNIFICANT FINDINGS</p> <p>SOCIAL HISTORY</p> <p><input type="checkbox"/> Tobacco _____</p> <p><input type="checkbox"/> Alcohol _____</p> <p><input type="checkbox"/> Recreational _____</p> <p><input type="checkbox"/> Drugs _____</p> <p><input type="checkbox"/> Abuse _____</p>
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HISTORY & PHYSICAL UPDATE (REQUIRED IF HSP IS + 24 HRS OUT + 30 DAYS SLR — 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: First floor Sc. P.A.T Cindy 586-493-8029

