

McLaren Print System Order

Order No: 89876
 Order Date: 2024-11-12
 User: Ljiljana Brkic
 Phone: 5863234576

Ship Location: HARRINGTON MEDICAL CENTER
 21510 HARRINGTON STE 300
 CLINTON TWP, MI 48036

Forms

Quantity: 500
 Paragon Dept No: 28500
 Dept Name: Outpatient Surgery Harrington Building -suite 300
 Company Number: 260

Order Total Price: 22.40

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 & INDICATORS FOR PROCEDURES</p> <p>PAST MEDICAL HISTORY (check 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"/> Abnormal Intestine <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Non-Insulin Dependent</p> <p><input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Rheuma <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"/> Psychiatric/PTSD <input type="checkbox"/> OSA <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> SEX: _____ Gender: _____ Race: _____ 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>PROSTATE (if applicable)</p> <p><input type="checkbox"/> MILD/SEVERE UP TO DATE <input type="checkbox"/> BRADYPROSTATITIS 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: _____ BMI: _____</p> <p>(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: _____ <input type="checkbox"/> Alcohol: _____ <input type="checkbox"/> Recreational: _____ <input type="checkbox"/> Drugs: _____ <input type="checkbox"/> Abuse: _____</p>
<p>DATE: _____ TIME: _____ PHYSICIAN SIGNATURE: _____</p>	
<p>HISTORY & PHYSICAL UPDATE (REQUIRED IF HSP IS + 24 HRS OUT + 30 DAYS OLD — Completed Day of Procedure)</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> A change HSP occurred in the patient's condition since previous HSP was completed within the last 30 days, noted below:</p> <p>TIME: _____ DATE: _____ PHYSICIAN SIGNATURE: _____</p>	

Spec Info: goldenrod paper

