

**McLaren Internal Medicine Residency Group Practice
FLINT, MICHIGAN**

CHIEF COMPLAINT: _____

Age: _____ B/P: _____ Smoker: _____
 Wt: _____ Pulse: _____ Pain level: _____
 Ht: _____ Temp: _____ LMP: _____
 BMI: _____ Resp. Rate: _____ Glucometer: _____

Refills:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent tests:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Consults:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood work:	Office	Lab
Injections:		

HPI:

ROS:

PFSH:

MEDICATION REVIEW:

PHYSICAL EXAM:

General Appearance: HEENT: Neck: Lymph Nodes: Breast: Respiratory:
 Cardiac: Abdomen: Pelvic/Rectal: Musculoskel: Neuro: Extremities: Skin:
 Peripheral Pulses:

ASSESSMENT:

1 _____
 2 _____
 3 _____
 4 _____
 5 _____
 6 _____

PLAN:

1 _____
 2 _____
 3 _____
 4 _____
 5 _____
 6 _____

Counseling Time: _____ Return Visit: _____

Physician Signature: _____

DOS: _____

PT.

D.O.B.

DR.

PROGRESS NOTES