

McLaren Print System Order

Order No: 53816
 Order Date: 2020-04-09
 User: Judy Fago
 Phone: 586-493-3610

Ship Location: Gratiot Medical Building
 36500 Gratiot, Suite 102
 Clinton Twp, MI 48035

Forms

Quantity: 500
 Paragon Dept No: 60320
 Dept Name: Family First
 Company Number: 260

Order Total Price: 18.00

Item Number: MO-416
 Item Description: Annual Gynecological Exam (Macomb).
 Revision Date: 3/2020
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold: None
 Finish: None
 Drill: 2 Hole Top
 Misc Info: ss; black & white

McLaren
MACOMB
Annual Gynecological Exam

Name: _____ G.O.B.: _____ Date: _____ Time: _____
 Hgt: _____ Wgt: _____ Bk: _____ Bkt: _____ Temp: _____ HR: _____ S/P: _____ Pulse: _____ Resp: _____

Allegiance: _____
 First day of last Menstrual Period: _____/_____/_____
 Abnormal Pap Smears: YES NO Age > 40: Last Mammogram: _____/_____/_____
 Abnormal: Abnormal Mammogram: YES NO
 Family History of Breast Cancer: YES NO Age > 50: Last Bone Density: _____/_____/_____
 Smoker: YES NO Colonoscopy: YES _____/_____/_____
 Abnormal Bleeding: YES NO Next due: _____/_____/_____

Other Complaints/Symptoms: _____

Physical Exam:

Ext. Genitalia: Normal Abnormal
 Vagina: Normal Abnormal
 Cervix: Normal Abnormal
 Uterus & Adnexa: Normal Abnormal
 Breasts: Normal Abnormal
 Rectum/Rectosigmoid: Normal Abnormal

HEENT: Normal Abnormal _____
 Heart: Normal Abnormal _____
 Lungs: Normal Abnormal _____
 Abdomen: Normal Abnormal _____
 Skin: Normal Abnormal _____
 Extremities: Normal Abnormal _____

Assessment: 1: _____ 4: _____
 2: _____ 5: _____
 3: _____ 6: _____

Plan: Reinforced healthy diet, lifestyle, exercise and safety. Over 40: Mammogram
 Pap Smear Over 50: Recommended to report postmenopausal bleeding

Other: _____
 1: _____ 4: _____
 2: _____ 5: _____
 3: _____ 6: _____

Next visit in _____ for _____ Resident Signature: _____
I personally interviewed and examined the patient today. I agree with findings and plan of care and have made any corrections to the documentation in the above notes.

Physician's Signature: _____ Date: _____/_____/_____ Time: _____

Spec Info: Peoplesoft cost center 58705-2360