

McLaren Print System Order

Order No: 59348 Reprint Previous Order No: 53760
Order Date: 2020-12-31
User: Laura Atsoff
Phone: 586-790-9003

Ship Location: McLaren Macomb Family First
36500 Gratiot, Suite 202
Clinton Twp , MI 48035

Forms

Quantity: 500
Paragon Dept No: 60320
Dept Name: McLaren Macomb 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: _____

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

Other Complaints/Symptoms: _____

Physical Exam:

Ext. Genitalia: Vaginal: Normal Abnormal
 Cervix: Normal Abnormal
 Uterus & Adnexa: Normal Abnormal
 Breasts: Normal Abnormal

Rectum/Rectosigmoid: Normal Abnormal

HEDN's: Normal Abnormal _____ Ovar Exam (Smoker): _____
 Heart: Normal Abnormal _____
 Lungs: Normal Abnormal _____
 Abdomen: Normal Abnormal _____
 Skin: Normal Abnormal _____
 Extremities: Normal Abnormal _____

Assessment:
 1: _____ 41: _____
 2: _____ 51: _____
 3: _____ 61: _____

Plan: Reinforced healthy diet, lifestyle, exercise and safety Over 40: Mammogram
 Pap Smear Over 50: Recommended to report postmenopausal bleeding
 Calcium 1200 mg/dl Colonoscopy Bone Density
 Labs: Cholesterol CBC CMP Thyroid Coated ASA, S25 mg/dl, B mg/dl
 Other: _____

1: _____ 41: _____
 2: _____ 51: _____
 3: _____ 61: _____

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: _____