McLaren Business Products

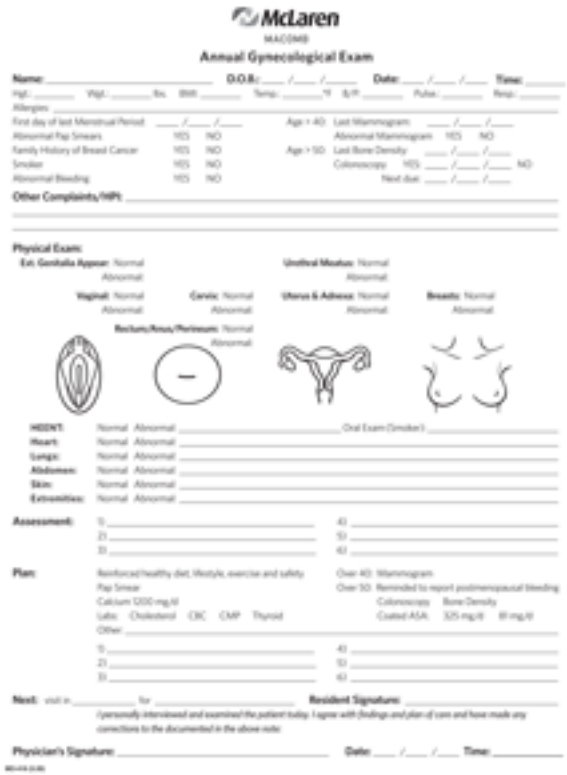
McLaren Print System Order

Order No: 63753 Reprint Previous Order No: 53760
Order Date: 2021-07-20
User: deborah simpson
Phone: 5864933670

Ship Location: Gratiot Medical Building
36500 Gratiot ste 202
clinton twp, mi 48035
Forms
Quantity: 500
Paragon Dept No: 58705
Dept Name: multi specialty clinic
Company Number: 260

Order Total Price: 0.00

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: None
Misc Info: ss; black & white



McLaren
MACOMB
Annual Gynecological Exam

Name: _____ D.O.B.: ___/___/___ Date: ___/___/___ Time: _____
Ht: _____ Wgt: _____ Bx: BMI _____ Temp: _____°F B/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/HPI: _____

Physical Exam:
Ext. Genitalia Appear: Normal Abnormal
Urethral Meatus: Normal Abnormal
Vaginal: Normal Abnormal
Cervix: Normal Abnormal
Uterus & Adnexa: Normal Abnormal
Breasts: Normal Abnormal
Rectum/Anus/Perineum: Normal Abnormal

HEENT: Normal Abnormal _____ Oral Exam (Smoker) _____
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
Pap Smear
Calcium 1200 mg/dl
Labs: Cholesterol CBC CMP Thyroid
Other _____
Over 40: Mammogram
Over 50: Reminded to report postmenopausal bleeding
Colonoscopy Bone Density
Coated ASA: 325 mg/dl 81 mg/dl
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 documented in the above note

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