History and Physical/Consultation

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

REVIEW OF SYSTEMS:

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

FAMILY HISTORY:
  • Can be addressed in other areas of documentation

SOCIAL HISTORY:

ALLERGIES:

CURRENT MEDICATIONS:

PHYSICAL EXAMINATION:
  • Pertinent diagnostic data (lab, radiology and other diagnostics)

ASSESSMENT AND PLAN:
  • Detail on diagnostics that are being ordered should be discussed in the assessment and plan

Inpatient Progress Note

SUBJECTIVE: History of Present Illness

OBJECTIVE: Physical Exam
  • Pertinent diagnostic data (lab, radiology and other diagnostics)

ASSESSMENT AND PLAN:
  • Detail on diagnostics that are being ordered and resulted for the day

DISPOSITION:
DISCHARGE SUMMARY

DATE OF ADMISSION:
DATE OF DISCHARGE:

PRIMARY CARE PROVIDER:

ADMITTING DIAGNOSIS:

DISCHARGE DIAGNOSES:

PROCEDURES:

PERTINENT IMAGING:

PERTINENT LABORATORIES:

HOSPITAL COURSE:

PHYSICAL EXAMINATION:

DISCHARGE DISPOSITION:

DISCHARGE MEDICATIONS:

DISCHARGE FOLLOWUP: