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HISTORY AND PHYSICAL

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ADMIT DATE: |CURRENT ADMISSION|

CURRENT DATE: |TODAY'S DATE|

EMERGENCY CONTACT

|CONTACT-EMERGENCY|

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PATIENT INFO:

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Chief Complaint

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HISTORY OF PRESENT ILLNESS

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|PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX|

Patient explains

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PAST MEDICAL HISTORY:

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|PROBLEM LIST ACTIVE|

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PROCEDURE HISTORY:

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|PROCEDURE HISTORY - BRIEF|

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ALLERGIES:

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|ALLERGIES/ADR|

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MEDICATIONS:

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|ACTIVE MEDS COMBINED|

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VITAL SIGNS

========================================================================

|LAST 3 VS|

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PHYSICAL EXAM:

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General: Atraumatic/normocephalic

Cardiovascular: Regular rate/rh

Pulmonary: No respiratory distress

Abdominal: Non distended, non-tender, soft

Neurological: No gross deficits

Extremities: warm/well perfused

Skin/Wound: C/D/I

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LABRATORY RESULTS:

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CHEM PANEL:

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|MHS CHEM-10|

|CALCIUM;1;99Y|

|MAGNESIUM;1;99Y|

|PHOSPHATE;1;99Y|

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CBC:

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|MHS CBC|

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COAGS:

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|INR;3;99Y|

|PTT;3;6M|

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LFTS:

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|LIVER PANEL;3;6M|

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NUTRITION LABS:

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|ALBUMIN;3;99Y|

|PREALBUMIN;1;99Y|

|CRP;3;99Y|

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UA:

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|UA;1;99Y|

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OTHER:

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|TROPONIN;3;2Y|

|LACTIC ACID;1;1D|

|HBA1C;1;99Y|

|CPK;1;99Y|

|LIPASE|

|AMYLASE|

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MICROBIOLOGY:

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|MICROBIOLOGY|

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IMAGING:

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|IMAGING REPORTS (6M)|

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PATHOLOGY:

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|SURG PATH ALL RESULTS|

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OTHER WORKUP:

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|MHS EKG|

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ASSESSMENT & PLAN:

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|PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX|

Given the above workup \*\*\*

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This case was discussed with \*\*\*