(place patient identification sticker here)

Methodist Healthcare

HT: _____

INTERNAL MED/HOSPITALIST
INT MED/HOSPITAL
(Adults 18 & older)

WT: _____

ALLERGIES: _____

DATE & TIME	PHYSICIAN'S ORDERS AND DIET	DATE & TIME	PROGRESS RECORD
			Note Progress of Case, Complications, Consultations, Change in Diagnosis, Condition on Discharge, Instructions to Patient.
			CC: Nonverbal/Comfortable
			VS: Tmax: / Afebrile HR: BP: / RR:
			NEURO: Motor def Y / N Sens def Y / N Oriented Y / N
			CV: Reg / Irreg M G R
			RESP: Clear Bil BS: Y / N Wheeze: Y / N O2 Sat:
			Rhonchi: Y / N Rales: Y / N Tachypneic Y / N
			ABD: Soft Tender: Y / N Distended: Y / N BS: Y / N
			Tympanic: Y / N Mass: Y / N TF:
			EXT: Edema: Cyanosis: Y / N
			LAB: 
			IMP/PLAN:
	Physician Sig: _____		Physician Sig: _____
	Physician ID# _____		Physician ID# _____
	Date _____ Time _____		Date _____ Time _____