

MICHIGAN STATE UNIVERSITY  
**INTERNAL MEDICINE**  
 INPATIENT  
**Progress Note**

|      |      |
|------|------|
| Date | Time |
|------|------|

**CC/ Reason for follow-up visit:**

**Interval History** (Hospital day No. ): (Including events since last visit)

**BILLING ATTENDING'S NOTES (if not primary scribe)**  
**Chief Complaint:**

**History:**  
 Or  3 chronic conditions addressed (see Assessment & Plan)

**Review of Systems:** (Required to have 1 finding from: 1system for level 2 & from 2 systems for level 3 visit)

- No dyspnea     No headache  
 No cough  
 No chest pain  
 No abdominal pain

Past Medical, Family and Social histories reviewed as documented previously (for level 3)  In addition:

|            |  |            |             |                |                                  |                |                                     |
|------------|--|------------|-------------|----------------|----------------------------------|----------------|-------------------------------------|
| <b>VS:</b> | Temperature  | Heart rate | Respiration | Blood pressure | Pulse oximetry<br>% on           | Intake/ output | Weight                              |
|            | <input type="checkbox"/> Foley catheter / <input type="checkbox"/> Nasogastric or feeding tube/ <input type="checkbox"/> Central line: |            |             |                | <input type="checkbox"/> Drains: |                | <input type="checkbox"/> IV fluids: |

**Examination:** (Guidelines: 2 findings each from - 1 system for level 1, - 3 systems for level 2 - 6 systems for level 3 visit)

I have examined the patient and agree as documented  
 Corrections made

**Examination: General:**  
 No significant distress

**Key findings are:**  
 No significant distress

**HEENT/ Mouth:**  Neck supple     Moist mucosa  
 No pharyngeal erythema

Neck supple  
 Moist mucosa

**Respiratory:**  No respiratory distress  
 Lungs clear to auscultation

No respiratory distress  
 Lungs clear to auscultation

**Cardiovascular:**  No Murmurs, rubs or gallops  
 No edema

No Murmurs, rubs or gallops  
 No edema

**Gastrointestinal:**  Abdomen non-tender  Normal bowel sounds  
 No hepatosplenomegaly

Abdomen non-tender  
 No hepatosplenomegaly

**Musculoskeletal:**  No joint tenderness  
 No muscle tenderness

No joint tenderness  
 No muscle tenderness

**Neurological:**  CN 3 to 12 symmetric  Alert; Oriented to person, place & time  
 Sensations normal

CN 3 to 12 symmetric  
 Alert; Oriented times 3

**Skin:**  Normal skin turgor  
 No new rashes

Normal skin turgor  
 No new rashes

**Medical Data:**

Anion gap: \_\_\_\_\_

|                     |                             |                   |
|---------------------|-----------------------------|-------------------|
| Sodium<br>Potassium | Chloride<br>CO <sub>2</sub> | BUN<br>Creatinine |
|---------------------|-----------------------------|-------------------|

Finger-stick  
Blood sugars:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

|                   |             |           |
|-------------------|-------------|-----------|
| Hgb<br>Hematocrit | Hemoalbumin | Bilirubin |
|-------------------|-------------|-----------|

Differential:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MCV: \_\_\_\_\_

|    |      |     |
|----|------|-----|
| PT | APTT | INR |
|----|------|-----|

- Will obtain old records  
 The data I reviewed includes that as documented on this form, and:  
 other lab results     consultant notes  
 radiology reports     radiology images  
 prior ECGs     ECG tracing  
 Additional history obtained from:  
 patient's family/attendants  
 Nursing staff  
 Discussed case with:

Initials: \_\_\_\_\_

Continued on next page

Attending's initials: \_\_\_\_\_

