

**SHORT STAY RECORD**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Present Illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Relevant Past Medical History and/or Currently Under Management:**

- Anemia
- GERD
- Hypercholesterolemia
- History of DVT
- Other: \_\_\_\_\_
- Chronic Kidney Disease
- COPD
- Mental Disorders: \_\_\_\_\_
- History of Cancer \_\_\_\_\_
- CVA- Residual Symptoms \_\_\_\_\_
- Hypertension
- Diabetes Mellitus 1 or 2  Controlled  Uncontrolled
- MI  Seizures  Epilepsy
- History of Hepatitis  History of Peptic Ulcer

**Surgeries / Injuries / Hospitalizations:** \_\_\_\_\_

**Relevant Family History:**

- Alcoholism  Asthma  Autoimmune Disease  Cancer: \_\_\_\_\_  Congestive Heart Failure
- Coronary Artery Disease  Diabetes Mellitus 1 or 2  Hypertension  Other: \_\_\_\_\_

**Relevant Social History / Psychosocial Needs:**

- Alcohol: \_\_\_\_\_  Tobacco: \_\_\_\_\_  Illicit Drugs: \_\_\_\_\_  Living Arrangements \_\_\_\_\_
- Marital Status:  Single  Married  Divorced  Widowed Occupation: \_\_\_\_\_
- Other: \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies:  NKA  yes, describe: \_\_\_\_\_

Bleeding Problems:  No  yes, describe: \_\_\_\_\_

Mental Status/Neurological:  Alert  Oriented  Confused  Disoriented  
 Other: \_\_\_\_\_

Pertinent review of systems:  Normal/Non-contributory  
 Abnormal: \_\_\_\_\_

**PHYSICAL EXAM**

	Normal	Abnormal, Describe
HEENT	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Extremities	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

Pertinent laboratory and radiology results: \_\_\_\_\_

**Impression:** \_\_\_\_\_

**Plan/Procedure to be performed:** \_\_\_\_\_

NP/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**DISCHARGE NOTE – For use with patients having Outpatient Surgery or hospitalized for less than 48 hours**

**Discharge Diagnosis:** \_\_\_\_\_

**Discharge Meds: See Home Medication Reconciliation for discharge medications**

**Home Care: Diet:**  Regular  Other \_\_\_\_\_ **Activity:**  No Restrictions  Restricted to: \_\_\_\_\_

**Follow-up**  Dr.: \_\_\_\_\_ **When:** \_\_\_\_\_

Signature of Person Recording Note: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**H&P Update Section (H&P > than 30 days old:**  
**A new H&P is required. The H&P has to be updated on date of admission.)**  
**H&P was reviewed; I have examined the patient and no changes occurred in their condition.**  
 Change in Exam: \_\_\_\_\_  
\_\_\_\_\_  
Physician Signature Date & Time