

HISTORY AND PHYSICAL – SHORT FORM

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History and physical examinations must be completed no more than 30 days prior to admission or surgery, before any procedure, and not more than 24 hours post admission.

Primary Physician: _____ **Surgeon:** _____

Date of Examination: _____ **Time:** _____ **Date of** _____ **Surgery:** _____

Procedure: _____

Wt.: _____ lbs _____ kg Ht.: _____ in _____ cm

Age: _____ OFC: _____ (<24 months of age) N/A

BP: _____ Pulse: _____ Resp: _____ T: _____ Last Menstrual Period: _____ N/A

Urine for pre-op pregnancy: (for 12 years and older or menstruating) **Should be done within 7 days of procedure.

Negative Positive

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS: _____

PAST MEDICAL HISTORY (Pregnancy/perinatal history, medical, exposures, diet, transfusions, medications):

PAST SURGICAL HISTORY:

ALLERGIES: _____

CURRENT MEDICATIONS

- No current medications
- Information not available

NOTE:

Please include all medications taken at home (vitamins, herbal remedies, homeopathic therapies and over-the-counter medications) in list of medications.

NAME	DOSE/ROUTE/FREQUENCY	START DATE	LAST TAKEN	PURPOSE

FAMILY HISTORY (Cardiac, cancer, respiratory, bleeding disorder, anesthetic reaction): _____

SOCIAL HISTORY (Current care taker, living situation, behavior-social adjustment): _____



PLACE PATIENT LABEL HERE

REVIEW OF SYSTEMS (All abnormal findings need comment)

Constitutional (fever, wt. loss, etc.)			
Respiratory			
Cardiovascular		A	
GI/Hepatic	N	B	
Neuro	O	N	
Urinary Tract/Renal	R	O	
Endocrine	M	R	
Mental/Development	A	M	
Vision/Hearing	L	A	
Musculoskeletal		L	
Skin			
Bleeding Disorder			
Tobacco/Alcohol/Drug Use			<input type="checkbox"/> N/A

Any use of aspirin or ibuprofen within 7 days of surgery? Yes No
 Anesthesia concerns/family history? Yes No Comment: _____
 Exposure to tobacco smoke? Yes No
 Immunizations up-to-date? Yes Not sure No, describe: _____

Exposure in the past 3 weeks to:

Chicken pox: No Yes, Date: _____ Whooping cough: No Yes, Date: ____
 Fifth disease: No Yes, Date: _____ Measles: No Yes, Date: _____
 Other: No Yes, Date: _____ Tuberculosis: No Yes, Date: _____ Treatment? No Yes

PHYSICAL EXAMINATION within 30 days of procedure (All abnormal findings need comment.)

Head			
Eyes			
Ears			
Nose			
Throat/Mouth			
Neck/Thyroid		A	
Chest	N	B	
Lungs	O	N	
Breasts	R	O	
Heart/Blood Vessels	M	R	
Abdomen/GI	A	M	
Neurologic	L	A	
Mental Status		L	
Muscular/Skeletal/Extremities			
Skin/Hair/Nails			
Genitalia/GU			
Lymphatic			

LAB (Hgb, A): _____

STUDIES (CXR, EKG, Head CT): _____

IMPRESSION: _____

Provider Signature: _____ **Date:** _____ **Time:** _____
Print Name Legibly: _____ **Phone/Pager #:** _____

Children's Provider has reviewed H&P from outside provider.

Patient ready for surgery/procedure.

No changes to documentation provided.

Physician Signature: _____

Changes noted as follows: _____

Date: _____ **Time:** _____

PLACE PATIENT LABEL HERE