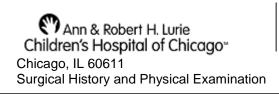
Ann & Robert H. Lurie
Children's Hospital of Chicago
Chicago, IL 60611
Surgical History and Physical Examination



Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

## SURGERY ADMISSION/OBSERVATION HISTORY & PHYSICAL EXAM

PATIENT HISTORY (use additional sheets as n	ecessary)
Patient Name:	
Informant:	
CHIEF COMPLAINT:	
HISTORY OF PRESENT ILLNESS:	
Past Medical History:	
Birth-If pertinent (include birth weight, gestational	age, complications)
Allergies (include medication, food, latex, other) _	
	. ,
Anesthesia (Difficulty with prior sedation/anesthes	ia)
Other medical conditions/diagnoses:	
Other medical conditions/diagnoses.	
Prior Surgeries:	
The daigenes.	
Prior Hospitalizations:	
Exposure to infectious disease in the past month:	
,	
<u>Medications</u> – List here or complete medication re	econciliation form
Immunizations: Up to date? Yes	No.
·	parental and sibling information or document "not noteworthy")
	parental and disting information of decament flot floteworthy /
Social History – If pertinent (If noteworthy, indicate	ate house and school situation, smoking, sexual activity or document "not
noteworthy")	, 3,



Patient Name: \_



Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

<b>REVIEW OF SYSTEMS</b> (If the response is yes for any of the following systems, seek consultation if necessary from appropriate specialty service)
History of neurological disorders?
Seizures/epilepsy?
Developmental delay?
VP shunt?
Asthma?
Respiratory Disorders?
Cystic Fibrosis?
History of heart disease?
Heart murmur?
Hypertension?
Kidney disease?
History of GI disease?
Liver disease?
Reflux?
Difficulties with chewing/swallowing or unintended weight loss?
History of endocrine disorders?
Diabetes?
Thyroid conditions?
Diabetes Insipidus?
Has patient taken steroids in the last two weeks?
Ever seen a hematologist for any type of blood disorder or bleeding problem?
Ever seen an oncologist or received chemotherapy or radiation therapy?
Immunological disorder?
Seen any other specialists?  If yes, please specify:

Ann & Robert H. Lurie
Children's Hospital of Chicago
Chicago, IL 60611
Surgical History and Physical Examination



Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Patient Name: _						
PHYSICAL EXA	<u>.M</u> (use additi	ional sheets as ı	necessary)			
Measurements			/eight	Head Circumferen	ce (infants)	
Vital Signs	Temp	H	R	RR	BP	
Overall descript	<u>t<b>ion</b></u> (include r	nental/psychiatric	c status, if applicable)			
Eyes:						
NECK:						
CHEST: Overall						
-						
ABDOMEN:						
GENITALIA:						
EXTREMITIES:						
NEUROLOGIC:						
SKIN:						
Other Physical	or Abnormal	Findings:				
Laboratory/Rad	iology/Other	Test Reports Re	eviewed:			
Assessment:						
Treatment Plan:	:					
Signature of	Examining Pro	ovider	Pager/Phone	Date		Time
To be complete	d day of surç	jery/procedure:				
I have reviewed documented).	the history a	and physical, ex	amined the patient ar	nd found no interval	change (change	es must be
		M.D./APN				
Printed	Name	_ 10.00,7 0 . 1	Signature	Pager/Phone	Date	Time