SURGERY ADMISSION/OBSERVATION HISTORY & PHYSICAL EXAM

PATIENT HISTORY (use additional sheets as necessary)

Patient Name: _____

Informant: _____ **Interpreter:** (Indicate Language _____)

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/anesthesia) _____

_____

Other medical conditions/diagnoses: _____

_____

Prior Surgeries: _____

_____

Prior Hospitalizations: _____

_____

Exposure to infectious disease in the past month: _____

_____

Medications – List here or complete medication reconciliation form

_____

_____

Immunizations: Up to date? Yes _____ No_____

Family History: (If noteworthy, indicate pertinent parental and sibling information or document "not noteworthy")

_____

_____

Social History – *If pertinent* (If noteworthy, indicate house and school situation, smoking, sexual activity or document "not noteworthy")

_____

_____

_____

Patient Name: _____

REVIEW OF SYSTEMS (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:

Patient Name: _____

PHYSICAL EXAM (use additional sheets as necessary)

Measurements Height_____ Weight _____ Head Circumference (infants) _____

Vital Signs Temp _____ HR _____ RR _____ BP _____

Overall description (include mental/psychiatric status, if applicable) _____

HEAD: _____

Eyes: _____

Ears: _____

NECK: _____

CHEST: Overall _____

Lungs: _____

Cardiac: _____

ABDOMEN: _____

GENITALIA: _____

EXTREMITIES: _____

NEUROLOGIC: _____

SKIN: _____

Other Physical or Abnormal Findings:

_____

Laboratory/Radiology/Other Test Reports Reviewed:

_____

Assessment:

_____

Treatment Plan:

_____

_____ _____ _____ _____
Signature of Examining Provider | Pager/Phone | Date | Time

To be completed day of surgery/procedure:

I have reviewed the history and physical, examined the patient and found no interval change (changes must be documented).

_____ M.D./APN _____ _____ _____ _____
Printed Name | Signature | Pager/Phone | Date | Time