

**HISTORY AND PHYSICAL FORM**

Patient \_\_\_\_\_ DOB \_\_\_\_\_

<b>Minneapolis</b> 2525 Chicago Avenue South Minneapolis, MN 55404 (612) 813-6191 (612) 813-7704 Fax	<b>St. Paul</b> 345 North Smith Avenue St. Paul, MN 55102 (651) 220-6505 (651) 220-7220 Fax	<b>Ritchie Day Surgery Center</b> 310 North Smith Avenue St. Paul, MN 55102 (651) 241-5540 (651) 241-5067	<b>Minnetonka</b> 6050 Clearwater Drive Minnetonka, MN 55343 (952) 930-8700 (952) 930-8690 Fax
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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

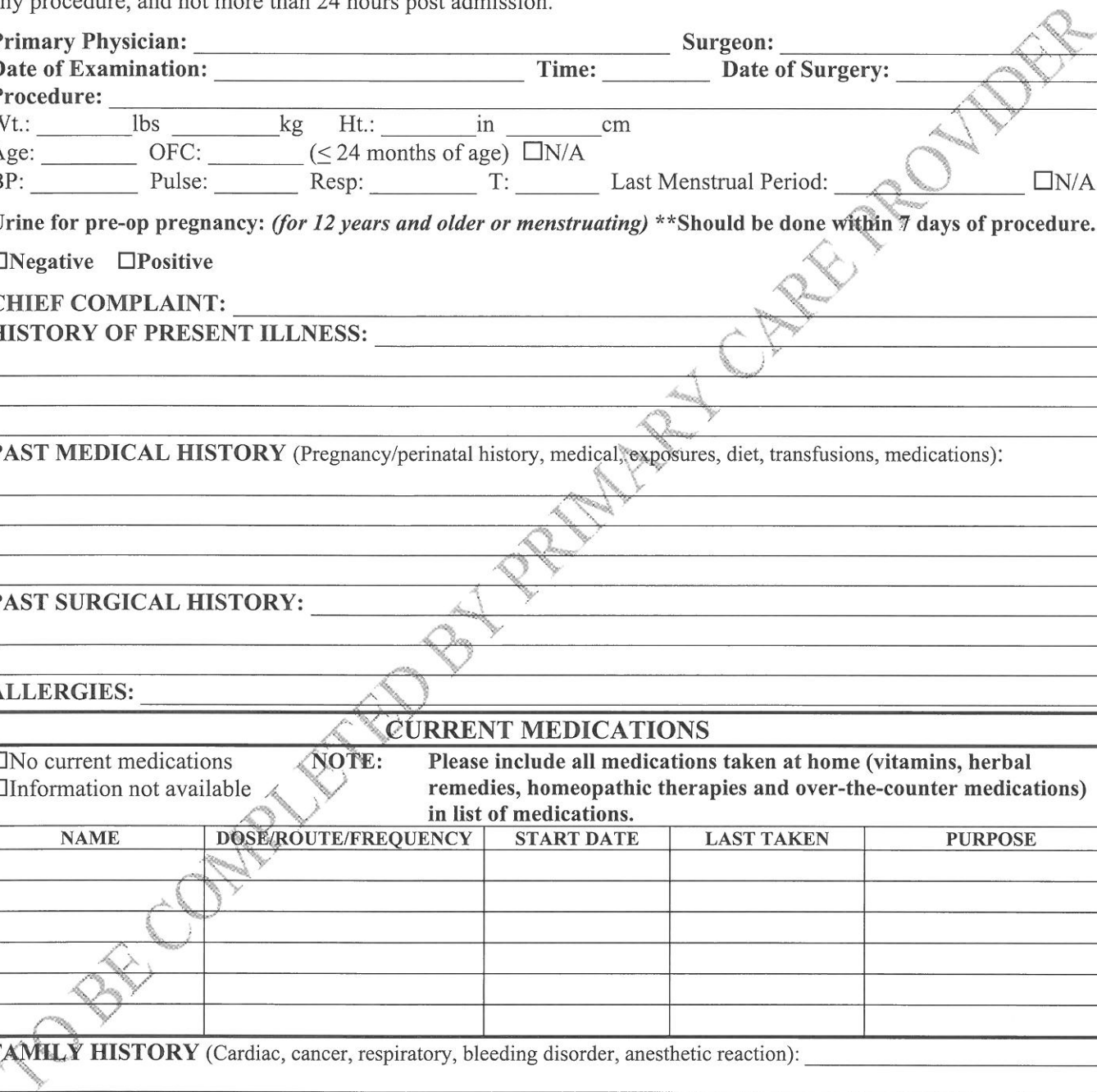
**NOTE:** Please include all medications taken at home (vitamins, herbal remedies, homeopathic therapies and over-the-counter medications) in list of medications.

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): \_\_\_\_\_

Your child must receive a physical examination by your child's primary care doctor within 30 days before surgery/procedure. (Please ignore if you are having a heart procedure.)



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**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, UA): \_\_\_\_\_

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: \_\_\_\_\_

Please ignore if you are having a heart procedure.)