Connecticut Children's Medical Center
282 Washington Street
Hartford, CT 06106

SHORT FORM HISTORY& PHYSICAL

Document information in boxes indicated or note that data is detailed on the reverse side of this form

UPON COMPLETION, PLEASE FAX TO: _____

Admitting MD	NAME:
Diagnosis	Date of Procedure
PROPOSED PROCEDURE (if applicable)	
HISTORY – PRESENT COMPLAINT	
Current Medications	

PAST MEDICAL HISTORY	FAMILY HISTORY	SOCIAL HISTORY
Allergies: ☐ Yes ☐No Previous Surgery/Hospitalizations: ☐ Yes ☐No Immunizations Up to Date: ☐ Yes ☐No	Anest. Rxn.: ☐ Yes ☐No Bleeding: ☐ Yes ☐No Other Pertinent:	Pertinent ☐ Yes ☐No

PHYSICAL EXAMINATION

HEIGHT _____ **cm** **WEIGHT** _____ **kg**

R.O.S. – any problems noted on reverse side	SYSTEM		Examined and WNL	Examined and Not WNL	Exam Deferred	Abnormalities/deferment explained here by system number
1 ☐	1. Eyes	1	☐	☐	☐	
2 ☐	2.. Ears, nose, mouth	2	☐	☐	☐	
3 ☐	3. Cardiovascular	3	☐	☐	☐	
4 ☐	4. Respiratory	4	☐	☐	☐	
5 ☐	5. Gastrointestinal	5	☐	☐	☐	
6 ☐	6. Genitourinary	6	☐	☐	☐	
7 ☐	7. Musculoskeletal	7	☐	☐	☐	
8 ☐	8. Skin	8	☐	☐	☐	
9 ☐	9. Neurologic	9	☐	☐	☐	
10 ☐	10.Psychiatric	10	☐	☐	☐	
11 ☐	11.Hematologic/Lymphatic	11	☐	☐	☐	
12 ☐	12.Other	12	☐	☐	☐	

LABORATORY **Hgb/Hct: (if applicable)**
Other:

MD Signature_____ **Date**_____
Time_____

DO NOT WRITE BELOW – FOR DAY OF SURGERY/PROCEDURE ONLY

Patient has been examined – H&P reviewed – No changes ☐
Patient has been examined – H&P reviewed – Changes noted below:

_____

MD Signature _____ ***Date*** _____ ***Time*** _____

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ADDITIONAL INFORMATION: This area is used to document information which would not fit on the other side, such as positives from the review of systems (R.O.S.)

OPERATIVE NOTE

Pre-Op Diagnosis:

Post-Op Diagnosis:

Operation / Procedure:

Surgeon: Assistant:

Anesthesiologist: Anesthesia:

Fluids:

EBL:

Drains: ☐ None

Findings:

Specimens: ☐ None

Patient's Condition Post-Op: ☐ Stable

MD Signature _____ Date _____ Time _____