Children's Hospitals and Clinics of Minnesota

HISTORY AND PHYSICAL FORM

Patient _____ DOB _____

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

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): _____

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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			☐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.
☐No changes to documentation provided.
☐Changes noted as follows: _____

Patient ready for surgery/procedure.
Physician Signature: _____
Date: _____ Time: _____