



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 THE CCMC PRE-OP  
 OFFICE FAX# (860) 545-9888**

Admitting MD		NAME:			
Diagnosis		Date of Procedure			
PROPOSED PROCEDURE (if applicable)					
HISTORY – PRESENT COMPLAINT					
Current Medications					
<b>PAST MEDICAL HISTORY</b> Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Surgery/Hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No Immunizations Up to Date: <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>FAMILY HISTORY</b> Anest. Rxn.: <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding: <input type="checkbox"/> Yes <input type="checkbox"/> No Other Pertinent:		<b>SOCIAL HISTORY</b> Pertinent <input type="checkbox"/> Yes <input type="checkbox"/> No
R.O.S. – any problems noted on reverse side	SYSTEM	<b>PHYSICAL EXAMINATION</b>			
		HEIGHT	WEIGHT		HC
		Examined and WNL	Examined and Not WNL	Exam Deferred	Abnormalities/deferment explained here by system number
1 <input type="checkbox"/>	1. Eyes	1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 <input type="checkbox"/>	2.. Ears, nose, mouth	2 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 <input type="checkbox"/>	3. Cardiovascular	3 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4 <input type="checkbox"/>	4. Respiratory	4 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5 <input type="checkbox"/>	5. Gastrointestinal	5 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6 <input type="checkbox"/>	6. Genitourinary	6 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7 <input type="checkbox"/>	7. Musculoskeletal	7 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8 <input type="checkbox"/>	8. Skin	8 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9 <input type="checkbox"/>	9. Neurologic	9 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10 <input type="checkbox"/>	10. Psychiatric	10 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11 <input type="checkbox"/>	11. Hematologic/Lymphatic	11 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12 <input type="checkbox"/>	12. Other	12 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>LABORATORY</b>		Hgb/Hct (when applicable):			
Other:				MLP/MD Signature _____ Date _____ Time _____	
<input type="checkbox"/> No Change <input type="checkbox"/> Changes _____					
				MLP/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 \_\_\_\_\_