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
Diagnosis
PROPOSED PROCEDURE (if applicable)

HISTORY – PRESENT COMPLAINT

Current Medications

PAST MEDICAL HISTORY
Allergies: Yes No
Previous Surgery/Hospitalizations: Yes No
Immunizations Up to Date: Yes No

FAMILY HISTORY
Anest. Rxn.: Yes No
Bleeding: Yes No

SOCIAL HISTORY
Pertinent Yes No

R.O.S. – any problems noted on reverse side

SYSTEM | HEIGHT | PHYSICAL EXAMINATION
<table>
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<tbody>
<tr>
<td>Examined and WNL</td>
<td>Examined and Not WNL</td>
<td>Exam Deferred</td>
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1. Eyes 1
2. Ears, nose, mouth 2
3. Cardiovascular 3
4. Respiratory 4
5. Gastrointestinal 5
6. Genitourinary 6
7. Musculoskeletal 7
8. Skin 8
9. Neurologic 9
10. Psychiatric 10
11. Hematologic/Lymphatic 11
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 ______________
UPON COMPLETION, PLEASE FAX TO: __________________________________________

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 ________________