



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 CT CHILDREN'S PRE-OP OFFICE
 FAX (860) 545-9888

Admitting MD		NAME:			
Diagnosis		Date of Procedure			
PROPOSED PROCEDURE (if applicable)					
HISTORY – PRESENT COMPLAINT					
Current Medications					
PAST MEDICAL HISTORY 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		FAMILY HISTORY Anest. Rxn.: <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding: <input type="checkbox"/> Yes <input type="checkbox"/> No Other Pertinent:		SOCIAL HISTORY Pertinent <input type="checkbox"/> Yes <input type="checkbox"/> No	
R.O.S. – any problems noted on reverse side	SYSTEM	PHYSICAL EXAMINATION			
		HEIGHT _____ cm	WEIGHT _____ kg		
		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"/>	
LABORATORY Hgb/Hct: (if applicable)		MD Signature _____ Date _____ Other: _____ Time _____			
Other:					
DO NOT WRITE BELOW – FOR DAY OF SURGERY/PROCEDURE ONLY					
Patient has been examined – H&P reviewed – No changes <input type="checkbox"/>					
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 _____