Children's Hospitals and Clinics of Minnesota

HISTORY & PHYSICAL FORM (FOR NON-HEART PATIENTS)

Patient Name _____ DOB _____

Minneapolis	St. Paul	Day Surgery – United	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 Fax	(952) 930-8690 Fax

History and physical examinations must be completed no more than 7 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 _____

Age _____ Wt. _____ kg Ht. _____ cm OFC _____ (≤ 24 months of age) M N/A

BP _____ Pulse _____ Resp _____ T _____ Last Menstrual Period _____ M N/A

Urine for pre-op pregnancy: ***(for 12 years and older or menstruating)*** ☐ **Negative** ☐ **Positive**

CHIEF COMPLAINT _____

HISTORY OF PRESENT ILLNESS _____

PAST MEDICAL HISTORY (pregnancy/perinatal history, medical, exposures, diet, development, transfusions, medications)

PAST SURGICAL HISTORY _____

ALLERGIES _____

CURRENT MEDICATIONS

M No current medications
M 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) _____

HISTPHYS

Your child must receive a physical examination by your child's primary care doctor within seven (7) days before surgery.
(Please ignore if you are a heart patient)

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Patient Name _____ DOB _____

SOCIAL HISTORY (current care taker, living situation, school, behavior-social adjustment) _____

REVIEW OF SYSTEMS (All abnormal findings need comment)

	NORMAL	ABNORMAL	
Constitutional (fever, wt. loss, etc.)			
Respiratory			
Cardiovascular			
GI/Hepatic			
Neuro			
Urinary Tract/Renal			
Endocrine			
Mental/Development			
Vision/Hearing			
Musculoskeletal			
Skin			
Bleeding Disorder			
Tobacco/Alcohol/Drug Use			M 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:
Chickenpox: ☐ 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 7 days of procedure (All abnormal findings need comment)

	NORMAL	ABNORMAL
Head		
Eyes		
Ears		
Nose		
Throat/Mouth		
Neck/Thyroid		
Chest		
Lungs		
Breasts		
Heart/Blood Vessels		
Abdomen/GI		
Neurologic		
Mental Status		
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.
Physician Signature: _____
Date: _____ Time: _____

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