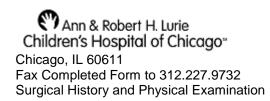
Ann & Robert H. Lurie
Children's Hospital of Chicago*
Chicago, IL 60611
Fax Completed Form to 312.227.9732
Surgical History and Physical Examination



Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

SURGERY ADMISSION/OBSERVATION HISTORY & PHYSICAL EXAM

PATIENT HISTORY (use additional sheets as necessary)					
Patient Name:					
Informant:	Interpreter: (Indicate Language)				
CHIEF COMPLAINT:					
HISTORY OF PRESENT ILLNESS:					
Past Medical History:					
Birth-If pertinent (include birth weight, gestational	l age, complications)				
Allergies (include medication, food, latex, other)					
A south a size (Different) and the size of a detical (a south as	-:->				
Anestnesia (Difficulty with prior secation/anestne	sia)				
Other medical conditions/diagnoses:					
Prior Surgeries:					
Prior Hospitalizations:					
Exposure to infectious disease in the past month	•				
Medications – List here or complete medication	reconciliation form				
Elst here of complete medication	Testination form				
Immunizations: Up to date? Yes	No				
Family History: (If noteworthy, indicate pertiner	nt parental and sibling information or document "not noteworthy")				
•	cate house and school situation, smoking, sexual activity or document "not				
noteworthy")					



Patient Name:



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REVIEW OF SYSTEMS (If the response is yes for any of the following systems, seek consultation if necessary from appropriate specialty service)
History of neurological disorders?
Seizures/epilepsy?
Developmental delay?
VP shunt?
Asthma?
Respiratory Disorders?
Cystic Fibrosis?
History of heart disease?
Heart murmur?
Hypertension?
Kidney disease?
History of GI disease?
Liver disease?
Reflux?
Difficulties with chewing/swallowing or unintended weight loss?
History of endocrine disorders?
Diabetes?
Thyroid conditions?
Diabetes Insipidus?
Has patient taken steroids in the last two weeks?
Ever seen a hematologist for any type of blood disorder or bleeding problem?
Ever seen an oncologist or received chemotherapy or radiation therapy?
Immunological disorder?
Seen any other specialists? If yes, please specify:

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Patient Name: _						
PHYSICAL EXA	M (use additior	nal sheets as ne	ecessary)			
Measurements	_		eight			
Vital Signs	-		·			
Overall descript	<u>tion</u> (include me	ntal/psychiatric s	status, if applicable) _			
HEAD:						
NECK:						
CHEST: Overall						
ABDOMEN:						
GENITALIA:						
EXTREMITIES:						
NEUROLOGIC:						
SKIN:						
Other Physical of	or Abnormal Fi	indings:				
-						
Laboratory/Rad	iology/Other Te	est Reports Rev	/iewed:			
Assessment:						
Treatment Plan:						
Signature of	Examining Provi	ider	Pager/Phone	Date	Time	
			-			
To be complete	d day of Surger	y/procedure.				
I have reviewed documented).	the history and	d physical, exar	mined the patient and	d found no interval ch	າange (changes mເ	ıst be
	,	M.D./APN				
Printed		VI.D./AFIN	Signature	Pager/Phone	Date	Time