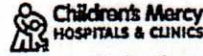


Patient Name

Surgery Clearinghouse  
Phone 816-855-1841

FAX to 816-302-9928



Surgery Admission  
Database

History & Physical

Informant: \_\_\_\_\_ Relationship: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

History of Present Illness (HPI): \_\_\_\_\_

Past Medical/Surgical History: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ gm

SEE HPI	NEGATIVE	REVIEW OF SYSTEMS
<input type="checkbox"/>	<input type="checkbox"/>	HEENT: _____
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular: _____
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal: _____
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary/Reproductive: LMP: ____ / ____ / ____ <input type="checkbox"/> Premenarchal: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bone/Skin/Joint: _____
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic: _____
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine: _____
<input type="checkbox"/>	<input type="checkbox"/>	Psychological: _____
<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Drugs/Alcohol Use/Abuse: _____

Allergies:  NKA  
Allergy \_\_\_\_\_ Type of Reaction \_\_\_\_\_ Allergy \_\_\_\_\_ Type of Reaction \_\_\_\_\_

Medications/Herbal Preparations/Dietary Supplements:  None \_\_\_\_\_

Immunizations Up-to-Date:  Unknown  Yes  No, explain: \_\_\_\_\_

PHYSICAL EXAM

Weight: \_\_\_\_\_ kg

General: \_\_\_\_\_

HEENT: \_\_\_\_\_

Neck/Lymphatics: \_\_\_\_\_

Lungs: \_\_\_\_\_

Breasts/Tanner Stage: \_\_\_\_\_  N/A

Cardiovascular/Pulses: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Rectal: \_\_\_\_\_  N/A

Genitalia/Tanner Stage: \_\_\_\_\_  N/A

Trunk: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

Neurological: \_\_\_\_\_

Other: \_\_\_\_\_

Laboratory/Radiology/Ancillary Results:  None \_\_\_\_\_

Assessment/Plan: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_ hours

PATIENT CONDITION UPDATE (to be completed on the day of surgery)

- H&P reviewed, patient examined, no changes to patient condition.  H&P reviewed, patient examined, changes as noted below.
- See medication reconciliation form for list of current medications.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_ hours