



060

**SURGICAL ADMISSION INPATIENT/AMBULATORY
FORM: HISTORY & PHYSICAL (H&P)**

CHIEF COMPLAINT & PRESENT ILLNESS: _____

MALE FEMALE IF FEMALE, LMP _____ LAST MAMMOGRAM _____ LAST PAP SMEAR _____

PAST MEDICAL HISTORY:

	Y	N	EXPLAIN:
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING/CLOTTING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
SLEEP APNEA	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREVIOUS SURGERY: **EXPLAIN:** _____

FAMILY HISTORY:

	Y	N	EXPLAIN:
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING/CLOTTING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
ANESTH. COMP.	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER THE COUNTER AND HERBAL MEDICATIONS.

Medication Name	Dose (mg. mcg)	Route	Frequency	Medication Reconciliation	Reason Not Continued
1.				<input type="checkbox"/> C <input type="checkbox"/> DC	
2.				<input type="checkbox"/> C <input type="checkbox"/> DC	
3.				<input type="checkbox"/> C <input type="checkbox"/> DC	
4.				<input type="checkbox"/> C <input type="checkbox"/> DC	
5.				<input type="checkbox"/> C <input type="checkbox"/> DC	
6.				<input type="checkbox"/> C <input type="checkbox"/> DC	
7.				<input type="checkbox"/> C <input type="checkbox"/> DC	
8.				<input type="checkbox"/> C <input type="checkbox"/> DC	

Reasons Not Continued: **S** - Substitution, **NPO**, **AR** - Adverse Reaction, **TO** - Taking Own Meds, **NT** - Not Tolerating Medication, **NI** - Not Indicated, **CD** - Dose Change, **H** - Hold

ALLERGIES & SENSITIVITIES: **Y** **N** **EXPLAIN:**

SOCIAL HISTORY:

	Y	N	EXPLAIN:
TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	_____
SUBSTANCE ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO NOT USE PROHIBITED ABBREVIATIONS

BETH ISRAEL MEDICAL CENTER SURGICAL ADMISSION INPATIENT/AMBULATORY FORM: HISTORY & PHYSICAL (H&P)

Patient Name _____ MR # _____ Acct # _____

REVIEW OF SYSTEMS:	POS.	NEG.	EXPLAIN:
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	_____
PAIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
CARDIO-VASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTRO-INTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITO-URINARY	<input type="checkbox"/>	<input type="checkbox"/>	_____
MUSCULOSKELETAL	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGIC/PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	_____
SLEEP DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____

PHYSICAL EXAM:

VITAL SIGNS - BP: _____ Pulse: _____ Resp: _____ Temp: _____ Ht: _____ Wt. _____

GENERAL APPEARANCE: _____

Note and Explain All Abnormal Findings:

SKIN & LYMPH NODES	<input type="checkbox"/>	Normal	_____
HEAD & NECK	<input type="checkbox"/>	Normal	_____
CHEST	<input type="checkbox"/>	Normal	_____
LUNGS	<input type="checkbox"/>	Normal	_____
HEART	<input type="checkbox"/>	Normal	_____
BREASTS	<input type="checkbox"/>	Normal	_____
ABDOMEN	<input type="checkbox"/>	Normal	_____
RECTAL	<input type="checkbox"/>	Normal	_____
PELVIC (FEMALE)	<input type="checkbox"/>	Normal	_____
MALE GENITALIA & PROSTATE	<input type="checkbox"/>	Normal	_____
EXTREMITIES	<input type="checkbox"/>	Normal	_____
VASCULAR	<input type="checkbox"/>	Normal	_____
NEUROLOGICAL	<input type="checkbox"/>	Normal	_____
PULSES	<input type="checkbox"/>	Normal	_____

OTHER PERTINENT FINDINGS: _____

ASSESSMENT: _____

PLAN OF TREATMENT: _____

If Ambulatory patient, state condition on discharge: _____

I certify that I have evaluated this patient _____ Date: _____ Time: _____

I certify that I have re-evaluated this patient and there has been no significant change in his/her clinical condition since the above examination.

I certify that I have re-evaluated this patient and there is a change in his/her clinical condition. See Progress Note.

Attending Physician Signature _____ Date: _____ Time: _____

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