Children's Mercy KANSAS CITY

History and Physical for Surgery/Procedure Form

Phone: (816) 855-1841
Fax: (816) 302-9928

Date: _____

PATIENT INFORMATION

First Name:_____ Last Name:_____ Gender: ____ DOB:___/___/_____

INFORMANT

First Name:_____ Last Name:_____ Relationship:_____
Chief Complaint: _____
History of Present Illness (HPI):_____

Past Medical/Surgical History/Family History/Problem List:_____
_____ Birth Weight:_____kg

REVIEW OF SYSTEMS

Constitutional:_____
HEENT:_____
Respiratory:_____
Cardiovascular:_____
Gastrointestinal:_____
Genitourinary:_____ LMP:___/___/___ ◯Pre-menarchal
Heme/Lymph:_____
Endocrine:_____
Immunologic:_____
Musculoskeletal:_____
Integumentary:_____
Neurologic:_____
Psychiatric:_____
Smoking/Drugs/Alcohol Use/Abuse:_____
◯All other ROS negative except those in HPI (at least 10 systems reviewed)
Adverse Reactions: ◯NKAR Adverse Reaction(s):_____ Type of Reaction:_____

Medications/Vitamins/Supplements (prescribed and over the counter): ◯None ◯Medication List attached
Immunizations Up-to-Date: ◯Current per ACIP and reviewed ◯Not Current per ACIP-record reviewed
◯Current per caregiver-record not available to be reviewed ◯Patient/caregiver declines vaccines ◯Other:_____

PHYSICAL EXAM

Vital Signs: Temp:_____ Pulse:_____ Resp. Rate:_____ Blood Pressure:____/___ Current Weight:_____kg Height:_____cm
General:_____
HEENT:_____
Neck/Lymphatics:_____
Respiratory:_____
Cardiovascular:_____
Gastrointestinal:_____
Genitourinary:_____ Genitalia/Tanner Stage:_____
Musculoskeletal:_____
Integumentary:_____
Neurologic:_____
Psychiatric:_____
◯Patient is medically clear for surgery/procedure Other:_____
Laboratory/Radiology/Ancillary Results: ◯None _____
Assessment/Plan:_____
Provider Signature:_____ Printed Name:_____ Date:___/___/___ Time:_____a.m./p.m.
Practice/Organization where the form was completed:_____