

DATE _____

Reason for Referral/Chief Complaint (Needs to be indicated by Attending at **all** levels)

Allergies/Reaction

- 1. See Pt/Nursing Intake notes
- 2. No Known Allergies
- 3.
- 4.

HPI by Attending (Chronologic description from onset to present. Elements include location, quality, severity, duration, timing, context, modifying factors, associated symptoms / signs.) All admits require ≥ 4 elements.

Medications: See Pt. / Nursing / Resident Intake Notes (include herbals/vitamins)

Hx not obtainable from pt/family due to pt condition or family not present. Document reason in HPI

Past, Family, Social History Visit Levels 2-3 require all 3 (Past Medical Hx / Family / Social Hx); Level 1 requires 1 area.

Informant: **Past Hx reviewed in PT/Nursing/Resident Note on** _____ **date**

Past Medical Hx:

- Birth history normal
- Growth & development normal
- No prior surgery
- No prior hospitalization
- Past visits reviewed in C.I.S.
- Previous/outside records reviewed

Immunizations current?

- Y (if available make copy of record)
- N (refer to PCP-see Hospital Policy)

Immunization(s) needed:

Other pertinent Hx:

Family Hx:

- No sick contacts
- Family hx of:

Social Hx:

- Resides with parent or guardian or other:
- In Child Care:

Environmental Hx:

- No Smoker in House
- Patient smokes
- Pets:
- Travel:

ROS: (circle pertinent positives or cross out negatives) **ROS** reviewed from Pt / Nursing / Resident Fellows Intake Notes on _____ date.

Visit Levels 2 and 3 require ≥ 10 systems; Level 1 requires 2-9 systems.

Constitutional: fever, fatigue, wt. loss, swollen glands

Endocrine: change in habitus, wt. gain

Eyes: crossing, pain, double vision, redness, drainage

Ear, Nose, Mouth, Throat:

Ear: pain, drainage, hearing loss

Nose: discharge, bleeding, sinusitis

Mouth/Throat: tooth pain, sore throat, hoarseness

Respiratory: wheezing, cough, respiratory distress, apnea, cyanosis

Cardiac: murmurs, chest pain

GI: Feeding/appetite (nl, decreased), nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain

GU: frequency, dysuria, hematuria. UOP (nl/increased/decreased). Male: discharge, pain, swelling. Female: abnormal discharge, menses, pain LMP: _____

Musculoskeletal: joint pain, swelling, weakness

Neurologic: headaches, lethargy, seizures, loss of consciousness

Psychiatric: significant sleep or mood disturbance or depression

Hematologic/Lymphatic: anemia, bleeding, jaundice. Swollen glands

Skin: rashes, lumps, edema

Other or abnormal ROS:

Children's
 Hospital & Regional Medical Center
 SEATTLE, WASHINGTON 98105
HISTORY/PHYSICAL EXAMINATION
Inpatient Admission

ADDRESSOGRAPH/LABEL

CASE NO.

NAME

B-DATE

CONSTITUTIONAL Head circ _____ cm (_____ %) Height _____ cm (_____ %) Weight _____ kg(_____ %) SaO ₂ _____% FiO ₂ _____% Temp _____ °C Pulse _____ RR _____ BP _____ GENERAL <input type="checkbox"/> Well Developed, Well Nourished in no acute distress <input type="checkbox"/> Distressed : (describe)		Ears, Nose, Mouth and Throat <input type="checkbox"/> TMs normal <input type="checkbox"/> Mucosa moist/pink <input type="checkbox"/> Nose & mucosa normal <input type="checkbox"/> Oral mucosa, gingiva & tongue normal <input type="checkbox"/> Dentition appropriate for age <input type="checkbox"/> Tonsils & pharynx normal	Eyes <input type="checkbox"/> Conjunctiva normal <input type="checkbox"/> Lids normal <input type="checkbox"/> Pupils/iris normal <input type="checkbox"/> PERRL/EOMI <input type="checkbox"/> No foreign body	
Neck <input type="checkbox"/> Normal exam of neck <input type="checkbox"/> Normal ROM <input type="checkbox"/> Normal thyroid gland <input type="checkbox"/> Supple	Skin <input type="checkbox"/> Dry & intact without rashes or lesions <input type="checkbox"/> Warm, dry <input type="checkbox"/> No petechiae/purpura	Respiratory <input type="checkbox"/> Normal chest shape <input type="checkbox"/> Clear to auscultation <input type="checkbox"/> Symmetric breath sounds <input type="checkbox"/> No stridor <input type="checkbox"/> No wheezing <input type="checkbox"/> No grunting <input type="checkbox"/> No flaring/retracting <input type="checkbox"/> Normal I:E ratio	Cardiac <input type="checkbox"/> No murmur/gallop/rub/thrill <input type="checkbox"/> Normal radial pulse, Capillary refill time <input type="checkbox"/> Normal pulse in groin <input type="checkbox"/> Normal pedal pulse <input type="checkbox"/> No edema	
Lymphatic <input type="checkbox"/> Normal cervical adenopathy <input type="checkbox"/> No axillary adenopathy <input type="checkbox"/> No groin adenopathy	Breasts <input type="checkbox"/> No masses or tenderness of breasts	Genitourinary Male Tanner Stage _____ <input type="checkbox"/> Normal phallus & scrotum <input type="checkbox"/> Testes descended, nl size/lie <input type="checkbox"/> No hernia, hydrocele, swelling Female Tanner Stage _____ <input type="checkbox"/> No masses or tenderness <input type="checkbox"/> No signs of vaginal discharge <input type="checkbox"/> Normal vulva & urethra <input type="checkbox"/> Pelvic examinations not done	Neurologic/Psych <input type="checkbox"/> Alert/Oriented <input type="checkbox"/> Cooperative for age/not irritable <input type="checkbox"/> Cranial nerves II-XII intact <input type="checkbox"/> Cerebellar normal (gait/coordination/balance) <input type="checkbox"/> Strength/tone normal for age all extremities <input type="checkbox"/> Sensation grossly intact <input type="checkbox"/> DTR's normal/symmetric <input type="checkbox"/> Cognition normal for age (memory/language/development) <input type="checkbox"/> Mood/affect normal	
Gastrointestinal (Abdomen) <input type="checkbox"/> Normal bowel sounds <input type="checkbox"/> No masses <input type="checkbox"/> No hepatosplenomegaly <input type="checkbox"/> Normal umbilicus <input type="checkbox"/> Perianal area without masses or tenderness <input type="checkbox"/> No guarding/rebound <input type="checkbox"/> No tenderness <input type="checkbox"/> No CVA pain				Musculoskeletal <input type="checkbox"/> No clubbing, digital pallor or cyanosis <input type="checkbox"/> Normal alignment, symmetry, ROM <input type="checkbox"/> No dislocation, subluxation, abnormal laxity or tenderness of joints <input type="checkbox"/> No joint effusions <input type="checkbox"/> No point tenderness <input type="checkbox"/> Normal digital sensation/circulation
DETAILED PE findings: (Abnormal/other) 				
Laboratory/Radiology/Other Tests Reviewed: <input type="checkbox"/> Test ordered/results reviewed in Clinical Information System (CIS)		Consults: <input type="checkbox"/> Medicine <input type="checkbox"/> Psych/SW <input type="checkbox"/> Other _____ <input type="checkbox"/> Hx and exam with interpreter		
ASSESSMENT AND PLAN (Updates to Plan of Care should be documented in daily progress notes and/or Interdisciplinary Plan of Care document). (Level of medical decision making based on combination of documented diagnosis or management options, amount & complexity of date reviewed, & overall risk to patient.) Level 3 medical decision making requires extensive #Dx/options, high complexity/risk. Level 2 requires mod #Dx/options, mod complexity/risk. Level 1 requires limited #Dx/options, low complexity/risk. <input type="checkbox"/> HPI/Past Medical/Social/Family Hx, ROS, PE, Test/Data/Assess & Plan reviewed with Resident / Team. See admit notes/ED chart/Clinic note _____/_____/_____ Attending statement: <input type="checkbox"/> I saw and evaluated the patient. I reviewed the resident's/fellow's note and agree with the Hx/PE/Plan except as noted: _____ (date)				
Diagnosis 1) _____ 2) _____ 3) _____				
<input type="checkbox"/> PCP notified _____		<input type="checkbox"/> continued on additional page		

DATE

(Printed Name)

(Signature)