Orthopædic Institute for Children

IN ALLIANCE WITH UCLA Health

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Physician Performing H&P:

Physician ID#: _____ Date of Exam: _____

Inpatient Attending Physician: _____

| Chief Complaint: |
|---|
| |

| History of Present Illness: |
|---|
| |

| Past History (Surgeries, illness, immunizations, transfusions): |
|---|
| |

| Medical Implants (G-tube, j-tube, VP shunt, baclofen pump, etc.) |
|---|
| |

## Review of Systems:

Constitutional: ☐ Denies all symptoms

Eyes: ☐ Denies all symptoms

ENMT: ☐ Denies all symptoms

Cardiovascular: ☐ Denies all symptoms

Respiratory: ☐ Denies all symptoms

Gastrointestinal: ☐ Denies all symptoms

Genitourinary: ☐ Denies all symptoms

Females: LMP _____

Musculoskeletal: ☐ Denies all symptoms

Skin and breast: ☐ Denies all symptoms

Neurological: ☐ Denies all symptoms

Psychiatric: ☐ Denies all symptoms

Endocrine: ☐ Denies all symptoms

Hematologic/Lymphatic: ☐ Denies all symptoms

Allergic/Immunologic: ☐ Denies all symptoms

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Patient Name: _____
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Current Medications:

Allergies: ☐ No known drug allergies

Habits:
Tobacco: ☐ None
Alcohol: ☐ None
Drugs: ☐ None
Other: ☐ None

Family and Social History:

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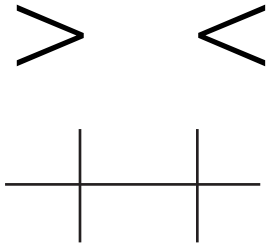
Age: _____ ☐ Male ☐ Female Height: _____ Weight: _____

Blood Pressure: _____/_____ Temperature: _____ Pulse: _____ Respiration: _____

General Appearance:
Skin:
Heent:
Neck:
Chest (thorax & breasts)
Lungs
Cardiac:
Abdomen:
Lymph Nodes:
Genitalia & Rectum:
Extremities:
Neurologic:

Test Results:

Laboratory



Imaging:

EKG:

Other:

**Assessment:**

**Plan:**

Resuscitation Status: ☐ Full Resuscitation ☐ No CPR Limited: See CODE BLUE STATUS FORM

Medical Decision Maker: Patient ☐ Agent ☐ Other: _____

| Date | Time | am/pm | Resident Signature | MD ID# |
|---|---|---|---|---|
| Date | Time | am/pm | Attending Signature | MD ID# |