

Patient Label

PHYSICIAN: HISTORY & PHYSICAL

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Exam Date: Age: Sex: F M Chief Complaint:

History of Present Illness:

Past Medical & Surgical History – *Relevant to operative or invasive procedure being performed:*

Family & Social History:

Tobacco History: Never Previous (Quit _____) Current Smoker Amount: _____ packs / day for _____ years

Allergies: None Latex Contrast Food or Medications - List:

Current Medications: None

Vital Signs Reviewed T P R B / P Weight

PHYSICAL EXAM	NORMAL	NA	ABNORMAL	FINDINGS
HEENT				
NECK				
LUNGS				
HEART				
ABDOMEN				
Relevant Area of Procedure				
OTHER				

Review of Systems:

Impression – Diagnosis:

Action Plan:

Informed Consent Discussion Completed I have reviewed the surgery or procedure with the patient. I have described the procedure, its possible risks and benefits, alternatives with their risks, and the likelihood of achieving care goals, and addressed any questions (PARQ process). To the best of my knowledge, the patient has been adequately informed, understands the information and has consented to the procedure.

ASA Physical Status Classification – Required for Sedation with Practitioner – see back of form for classification explanations:
 Class 1 Class 2 Class 3 Class 4 Class 5 Class 6 Emergency Surgery or Procedure

DATE: TIME: Practitioner Signature: Practitioner ID#

HISTORY & PHYSICAL - REQUIRED ELEMENTS & TIMELINES

MEDICAL STAFF RULES & REGULATIONS - H & Ps

It is the responsibility of the medical staff to assure that a medical history and appropriate physical examination (H&P) is performed on patients being admitted for inpatient care, as well as prior to surgery or a procedure requiring anesthesia services in either an inpatient or outpatient setting. H&Ps shall meet the following requirements:

PRIVILEGED PRACTITIONERS

All medical history and physical examinations shall be performed by practitioners granted such privileges by the governing board and in accordance to state law and hospital policy.

A history and physical shall document the

1. Chief complaint;
2. Details of present illness;
3. Relevant past medical, social, and family history (appropriate to the patient's age);
4. Summary of relevant psychosocial needs (appropriate to the patient's age);
5. Vital signs;
6. Allergies;
7. Medications;
8. An inventory of relevant body systems;
9. A physical exam (at a minimum, heart and lung and relevant areas);
10. Conclusions and impressions;
11. The course of action planned for the patient for this episode of care.

H&P TIME FRAME

A medical history and physical examination shall be completed and documented no more than thirty (30) days before and twenty-four (24) hours after admission or registration, **but prior to any surgery or a procedure requiring anesthesia services—whichever comes first.**

H&P PHYSICALLY ACCESSIBLE

The medical history and physical examination must be placed in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to any surgery or a procedure requiring anesthesia services - whichever comes first.

EMERGENT SITUATIONS

In emergent situations - when it is in the best interest of the patient to postpone the medical history and physical examination - the practitioner shall make a comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

ASA (American Society of Anesthesiologists) PHYSICAL STATUS CLASSIFICATION

Class 1: Normal, healthy patient.

Class 2: A patient with mild systemic disease.

Class 3: A patient with severe systemic disease.

Class 4: A patient with severe systemic disease that is a constant threat to life.

Class 5: A morbid patient who is not expected to survive without the operation or procedure.

Class 6: A patient who has been declared brain-dead & whose organs are being removed for donor purposes.

Class E: Emergency surgery or procedure.