



THE UNIVERSITY OF CHICAGO
COMER CHILDREN'S HOSPITAL

At the Forefront of **KIDS** Medicine

DEPARTMENT OF PEDIATRICS

**Inpatient Admission,
History & Physical**

**Initial Inpatient
Consultation**

PATIENT NUMBER

CLINIC OR FLOOR

DATE

Date: _____ Time: _____ Resident: _____

Primary care physician: _____ Referring physician: _____

Requesting physician (consult): _____

HISTORY OF PRESENT ILLNESS (HPI)

History unobtainable. Reason: _____

Chief complaint (CC): _____

Narrative: _____

HISTORY

(location / duration / quality / context / severity / timing / modifying factors / associated signs & symptoms)

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY:

Non-contributory or not applicable

PAST SURGICAL HISTORY:

Non-contributory or not applicable

ALLERGIES:

NKDA

FAMILY HISTORY:

Non-contributory or not applicable

SOCIAL HISTORY:

Non-contributory or not applicable

Discussed discharge planning

Discussed car seat / transportation

Discussed clothing

IMMUNIZATIONS:

DEVELOPMENTAL DELAY:

MEDICATIONS:

REVIEW OF SYSTEMS

REVIEW OF SYSTEMS:

Check appropriate box, describe if abnormal

All others unremarkable

Un = unremarkable Ab = abnormal

<input type="checkbox"/> Un <input type="checkbox"/> Ab Constitutional	<input type="checkbox"/> Un <input type="checkbox"/> Ab Musculoskeletal
<input type="checkbox"/> Un <input type="checkbox"/> Ab Eyes	<input type="checkbox"/> Un <input type="checkbox"/> Ab Integumentary
<input type="checkbox"/> Un <input type="checkbox"/> Ab ENT	<input type="checkbox"/> Un <input type="checkbox"/> Ab Neurological
<input type="checkbox"/> Un <input type="checkbox"/> Ab Cardiovascular	<input type="checkbox"/> Un <input type="checkbox"/> Ab Psychiatric
<input type="checkbox"/> Un <input type="checkbox"/> Ab Respiratory	<input type="checkbox"/> Un <input type="checkbox"/> Ab Endocrine
<input type="checkbox"/> Un <input type="checkbox"/> Ab Gastrointestinal	<input type="checkbox"/> Un <input type="checkbox"/> Ab Hematologic/Lymphatic
<input type="checkbox"/> Un <input type="checkbox"/> Ab Genitourinary	<input type="checkbox"/> Un <input type="checkbox"/> Ab Allergy/Immunologic

OTHER ROS COMMENTS:

PHYSICAL EXAMINATION

ORGAN SYSTEMS (COMMENT ON ABNORMAL AND PERTINENT UNREMARKABLE FINDINGS)

CONSTITUTIONAL: (e.g., vital signs, general appearance)

Check here if unremarkable

T: _____ P: _____ Resp: _____ BP: _____

O²sat: _____ WT: _____ Input: _____ Output: _____

EYES

Check here if unremarkable

EARS, NOSE, MOUTH, THROAT

Check here if unremarkable

LYMPHATIC/HEMATOLOGIC/IMMUNOLOGIC

Check here if unremarkable

CARDIOVASCULAR

Check here if unremarkable

RESPIRATORY

Check here if unremarkable

GASTROINTESTINAL

Check here if unremarkable

GENITOURINARY

Check here if unremarkable

MUSCULOSKELETAL

Check here if unremarkable

NEUROLOGIC

Check here if unremarkable

SKIN

Check here if unremarkable

PSYCHIATRIC

Check here if unremarkable

BODY AREAS (Un = unremarkable, Ab = abnormal). COMMENT ON ABNORMAL AND PERTINENT UNREMARKABLE FINDINGS.

Un Ab HEAD, including face

Un Ab CHEST, including breast and axillae

Un Ab GENITALIA, GROIN, BUTTOCKS

Un Ab EACH EXTREMITY

Un Ab NECK

Un Ab ABDOMEN

Un Ab BACK, including spine

Laboratories/Tests Reviewed or Ordered (summarize all "YES" responses):

1) *Lab/Pathology*

Results discussed w/ performing physician?

2) *Radiology*

Results discussed w/ performing physician?

3) *Medicine Tests*

Results discussed w/ performing physician?

4) *Independent visualization--image/tracing/specimen itself (NOT REVIEW OF REPORT):*

5) *Additional data collected: Summary is mandatory as detailed in parantheses for each entry.*

Reviewed old records (indicate type of record & content reviewed):

Obtained hx from other than patient (indicate history & from whom):

Discussed w/ another health care provider (indicate what was discussed & w/ whom):

DATA ELEMENTS

Resident/Fellow Signature & Pager #

ATTENDING DOCUMENTATION

ATTESTATION EXAMPLES: "I saw and evaluated the patient. I agree with the findings and the plan as documented in the fellow/resident's note (or I revise as follows)" **OR** "I saw and evaluated the patient with the fellow/resident and agree with the fellow/resident's findings and plan (or I agree except...)."

ATTESTATION: _____

Chemotherapy comments

• Med administration record sheet reviewed?	Yes	No	• Unusual reactions to chemotherapy? If yes, comment below.	Yes	No
• Chemotherapy scheduled for today?	Yes	No	• Patient and family coping effectively with therapeutic plan and hospitalizations?	Yes	No
• Prior chemotherapy on this admission?	Yes	No			

ADDITIONAL COMMENTS:

RISK LEVEL:

MINIMAL LOW *MODERATE *HIGH

*Explanation of moderate or high risk.

ATTENDING SIGNATURE

DATE