Dartmouth-Hitchcock
MEDICAL CENTER

One Medical Center Drive, Lebanon, NH 03756

Pre-Procedure History & Physical Examination

Addressograph

History & Physical completed by: ☐ DHMC Staff Clinician ☐ non-DHMC Staff Clinician

Chief Complaint/Diagnosis: ______________________________ Patient Age: _______ Code Status: ___________

Planned Procedure: ____

____

____

History of Present Illness: ____

____

____

____

Medical/Surgical History: ____

____

____

____

Family History: ____

____

____

Social History: ____

____

____

Advanced Care Planning: ____

(Write name of Durable Power of Attorney for Health Care or patient's preferred medical decision-maker and relationship to patient.)

Advise patient that this named person would be asked to give medical consent on behalf of the patient to all medical treatments related to the current Operative or Major Diagnostic or Therapeutic Procedure identified above. This named person's authority will only exist when the patient is unable to make his/her own medical decisions. Consideration should be given to postponing procedures under circumstances in which no medical decision-maker is identified.

Drug/Latex Allergies/Sensitivities: ____

____

☐ ADR/Allergies List reviewed and updated in EMR

☐ No known allergies

Current Medications: ____

____

☐ Medication list reviewed and updated in EMR

Review of Systems (ROS)

1) Pertinent positive findings: ____

____

☐ None

2) Remaining ROS (including: Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Neurological, Psychiatric, Endocrine, EENT): ____

____

☐ All negative

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Physical Exam (Complete each item. Explain abnormal.)

Height: __________ Weight: __________ (kg) Vital Signs: BP: _________ P: _________ R: _________ T: _________

	Normal	Abnormal	Not Examined	Explanations
Constitutional/General	❑	❑	❑	
Neurologic	❑	❑	❑	
EENT & Mouth	❑	❑	❑	
Neck/Thyroid	❑	❑	❑	
Skin	❑	❑	❑	
Musculoskeletal	❑	❑	❑	
Lungs	❑	❑	❑	
Heart	❑	❑	❑	
Peripheral Vascular	❑	❑	❑	
Breasts and Axillae	❑	❑	❑	
Abdomen	❑	❑	❑	
Pelvic	❑	❑	❑	
Scrotum/Testes	❑	❑	❑	
Rectal	❑	❑	❑	

Pertinent Data: ____

____

Assessment/Plan: ____

____

____

Pre-Procedure Orders:

❑ **Pre-Anesthesia Consult (schedule through Pre-Admission Testing): Required for non-emergency patients for whom Anesthesia Services are anticipated if patient has DNR or Limited Resuscitation Order or Out-of-Hospital DNR Order. Consult is recommended but optional prior to 12/31/08.**

❑ ____

❑ ____

❑ ____

Examiner Signature: ______________________ Print Name: __________________ Date: _________ Time: ________

24-Hour Interval H&P **Code Status:** ____________________

❑ Condition changed (see note) ❑ Condition unchanged since H&P originally performed

For DNR or Limited Resuscitation status Patients: "Documentation of Patient wishes during the peri-procedural time period for Patients with: DNR or Limited Resuscitation Order or Out-of-Hospital DNR Order" form

❑ Completed ❑ Not Completed (optional prior to 12/13/08)

Examiner Signature: ______________________ Print Name: __________________ Date: _________ Time: ________

H&P Review by DHMC Attending Physician

I have reviewed the pre-procedure H&P and subsequent interval H&P, as applicable and

❑ Find no need to add additional information **OR**

❑ Would add the following information: ____

Signature: ______________________ Print Name: ______________________ Date: _________ Time: _________