THE LUSKIN Orthopaedic Institute for Children IN ALLIANCE WITH UCLA Health

Expert Orthopaedic Care For All Children Since 1911
403 West Adams Boulevard, Los Angeles, CA 90007-2664

Cerebral Palsy History and Physical Exam

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

Patient Name: ______________________________

Date of Birth: ______________________________

Medical Record #: ______________________________

Current Medications:

Allergies: ☐ No known drug allergies

Habits:

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

Family and Social History:

Patient Name: ____

Date of Birth: ____

Medical Record #: ____

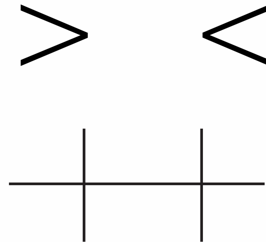
Age: __________ ☐ Male ☐ Female Height: __________ Weight: __________

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:** ______________________

__________ __________ am/pm ______________________ ______________
Date Time Resident Signature **MD ID#**

__________ __________ am/pm ______________________ ______________
Date Time Attending Signature **MD ID#**