Pediatric Surgery/Special procedure History and Physical

Name: Age: DOB: / /

Diagnosis:

Planned Procedure:

Present and Recent Illness:

Medications:

Allergies:

Immunizations: up to date Yes ☐ No ☐ Explain:

Medical/Surgical History	Yes	No	Details of Positive Responses
1. **PREVIOUS SURGERY/HOSPITALIZATION**			
2. **PAST ANESTHESIA HISTORY**			
3. **PREMATURITY** (gestational age, Birth weigh, Ventilation,Apnea, Prolonged intubation, trach.)			
4. **RESPIRATORY** (e.g., Snoring, Apnea, Croup, Asthma)			
5. **CARDIOVASCULAR (**e.g., Heart Murmur, HTN, CHD)			
6. **GI** (Reflux)			
7. **RENAL/URINARY**			
8. **HEMATOLOTY/ONCOLOTY** (bleeding, transfusion Chemo/RT)			
9. **ENDOCRINE/METABOLIC**			
10**. NEURO/SEIZURE**			
11**. Other**			

Physical Exam:

Wt: _____ lbs. Ht: _____ in. BP____/____ HR:_____ T:_____ RR: _____
_____kg. _____ cm.

Physical Appearance: _____

HEENT: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Mental Status: _____

Others: _____

Laboratory Results N/A ☐ CBC ☐ PT/PTT ☐ UA ☐

Cleared for Anesthesia/Surgery/Surgical Procedure ☐ Yes ☐ No

Signature:_____ Print Name: _____

Office Phone Number _____ Date:_____