Name:_____
DOB:_____
Surgeon:_____
Surgery:_____
Anesthesia Type:_____
Date of Surgery: _____

MEDARVA
STONY POINT SURGERY CENTER
8700 Stony Point Parkway
Richmond, VA 23235

PLEASE FAX TO Pre Admissions
Fax#: (804)545-0313

PEDIATRIC MEDICAL HISTORY & PHYSICAL EXAM (age ≤12)

Must be completed within the 30 days prior to surgery

PAST MEDICAL HISTORY

Hospitalization/Illness w/in 6mon Details:	yes	no
Hypertension	yes	no
Valve Dz	yes	no
Cardiac Abnormality	yes	no
Murmur Evaluation Date:_____	yes	no
Asthma	yes	no
ER visit(s) – Date:_____	yes	no
Hospitalization(s) – Date:_____	yes	no
RSV – Date:_____	yes	no
High BMI (Score:_____)	yes	no
Sleep Apnea	yes	no
Prematurity (complete if <1yr old) Gestational age:_____wks	yes	no
Developmental Delay	yes	no
ADHD/ADD	yes	no
Autism/Aspergers	yes	no
Cerebral Palsy	yes	no
Spina Bifida	yes	no
Seizures	yes	no
Down Syndrome	yes	no
Atlantoaxial Instability	yes	no
Diabetes	yes	no
Insulin	yes	no
GERD	yes	no

Hx Latex Reaction	yes	no
Anesthesia Problem		
Patient:	yes	no
Family:	yes	no
Family Hx of Malignant Hyperthermia	yes	no

☐ CLEARED FOR SURGERY

Date of Exam: _____
Physician Completing Form
Printed Name: _____
Signature: _____

Chief Complaint:_____

_____
Medications:_____
_____
_____
_____
Allergies & Reactions:_____
_____
_____
SURGICAL HISTORY:_____
_____
_____

PHYSICAL EXAM

HR_____ BP___/___ RR_____
Temp____ Ht_____ Wt_____
Oriented x 3: yes no
HEENT □ Normal □N/A_____
_____
Cardiovascular □ Normal _____
_____
Lungs □ Normal _____
_____
Abd □ Normal □N/A_____
_____
Neuro □ Normal □N/A_____
_____

SPECIAL NOTES

_____
_____
_____
_____
_____
_____

Reviewing Physician/Surgeon

Signature:_____ ____ **Date:** _____