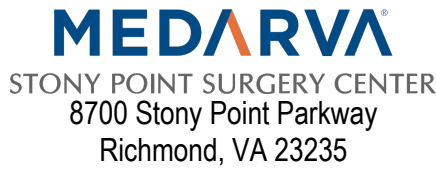


Name: _____
 DOB: _____
 Surgeon: _____
 Surgery: _____
 Anesthesia Type: _____
 Date of Surgery: _____



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	yes	no
Details:		
Hypertension	yes	no
Valve Dz	yes	no
Cardiac Abnormality	yes	no
Murmur	yes	no
Evaluation Date: _____		
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)	yes	no
Gestational age: _____ wks		
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: _____