MEDRVA SURGERY CENTERS
PEDIATRIC HISTORY AND PHYSICAL (AGE ≤12)

PLEASE EMAIL OR FAX TO preadmission@medrva.com or 804-545-0313

Patient Name: _____
Date of Birth: _____
Height: _____ Weight: _____ BMI: _____
BP: _____ HR: _____ HR: _____
Surgeon: _____
Surgery: _____
Anesthesia: _____
Date of Surgery: _____
HX Anesthesia Problem:
Patient: Yes ☐ No ☐
Family: Yes ☐ No ☐
Details: _____
HX Latex Reaction: Yes ☐ No ☐

HEENT: Normal ☐ _____
Heart: Normal ☐ _____
Lungs: Normal ☐ _____
Abd: Normal ☐ NA ☐
Neuro: Normal ☐ NA ☐
Oriented x3: Yes ☐ No ☐
Family HX of Malignant Hypothermia: Yes ☐ No ☐

Chief Complaint: _____
Medications: _____
Allergies & Reactions: _____
Surgical History: _____
Special Notes: _____

Past Medical History

	YES	NO		YES	NO
Hypertension			GERD		
Down Syndrome			Seizures		
RSV - Date: _____			Spinal Bifida		
Atlantoaxial Instability			Autism/Asperger		
Sleep Apnea			Cerebral Palsy		
Developmental Delay			ADHD/ADD		
Cardiac Abnormality Details: _____			Murmur (Evaluation Date: _____)		
			Asthma		
Diabetes			ER visit(s) - Date: _____		
Insulin			Hospitalization(s) - Date: _____		
Hospitalization w/in 6 months Details: _____			Prematurity (complete if <1yr) Gestational Age: _____ wks		

☐ **CLEARED FOR SURGERY**

Date of Exam: _____

Physician Completing Form
Printed Name: _____
Physician Signature: _____

Reviewing Physician/Surgeon
Physician Signature: _____
Date: _____

All H&P's must be completed within 30 days of the surgery