

PREOPERATIVE HISTORY AND PHYSICAL EXAM

The child must be examined and the history and physical examination must be documented within thirty (30) days prior to a surgical procedure by a licensed provider. **Please fax completed form to 513.872.6115.**
 Feel free to attach any additional information that you feel is pertinent to the surgical care of this patient.

Name: _____ DOB: _____

Surgical Procedure: _____ Date of Procedure: _____

Allergies & Reaction: _____

Medications: _____

Immunizations UTD: YES NO Comment: _____

Significant Medical History:

1) Asthma YES NO

Comments: (including current regimen, recent hospitalizations, exacerbations, or issues, etc.)

2) Bleeding Disorder YES NO

Comments:

3) Recent Illness/Exposure YES NO

Comments:

Other Significant Medical History (including any concerns with obstructive sleep apnea): N/A _____

Past Surgical History: N/A _____

Significant Family History: N/A _____

Height: _____ Weight: _____ Temp: _____ BP: _____ Pulse: _____ Respiratory: _____ Pulse Ox: _____

| Physical Examination | Normal | Abnormal | Comment |
|------------------------|--------|----------|---------|
| Growth and Development | | | |
| Appearance | | | |
| HEENT | | | |
| Cardiovascular | | | |
| Respiratory | | | |
| GI/Abdominal | | | |
| Musculoskeletal | | | |
| Integument | | | |
| Neurologic | | | |

Date of Exam

Primary Care Provider's Name (print) / Signature

Office Phone

Office Address

Preoperative History and Physical Exam



Shriners Hospitals
for Children®

Cincinnati

Pediatric Specialty Care
Burns
Cleft Lip and Palate
Specialized Plastic Surgery

