



**PRE-PROCEDURE
PHYSICAL EXAM FORM**

Name: _____

DOB: _____

The child must be examined and the history and physical examination must be documented within seven (7) days prior to a surgical procedure by a state licensed clinician.

Date of exam: _____ Date of surgery: _____

Surgical procedure: _____

Diagnosis/presenting problem: _____

Significant medical history: _____

HISTORY

Allergies: No Drug/Contrast Allergy No Food Allergy No Product/Latex Allergy Unable to Obtain Allergy Information

Specifics: _____

	No	Yes	Comments
Current medications:	<input type="checkbox"/>	<input type="checkbox"/>	
Steroids past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	
Previous anesthesia:	<input type="checkbox"/>	<input type="checkbox"/>	
Recent infection/exposure:	<input type="checkbox"/>	<input type="checkbox"/>	
Immunizations needed:	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures:	<input type="checkbox"/>	<input type="checkbox"/>	
Croup/wheezing:	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding tendency: Patient:	<input type="checkbox"/>	<input type="checkbox"/>	
Family:	<input type="checkbox"/>	<input type="checkbox"/>	

PHYSICAL EXAMINATION

Ht _____ cm Wt _____ kg Temp _____ °C Pulse _____ BP _____ / _____

	NL	ABNL	Comments
Appearance:	<input type="checkbox"/>	<input type="checkbox"/>	
Skin/lymph:	<input type="checkbox"/>	<input type="checkbox"/>	
Head, eyes, ears, nose, throat:	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth:	<input type="checkbox"/>	<input type="checkbox"/>	
Heart:	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs:	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal:	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia:	<input type="checkbox"/>	<input type="checkbox"/>	
Extremity:	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic:	<input type="checkbox"/>	<input type="checkbox"/>	

Special Instructions: _____

Clinician Signature/Credentials

I have reviewed the above history and physical and will proceed with the procedure.

Additional comments: _____

Physician Signature/Credentials

Date

