

**PRE-SURGICAL
MEDICAL HISTORY / PHYSICAL EXAM**

PATIENT NAME: _____ **DATE OF EXAM:** / / **TIME:** _____

Chief Complaint: _____

Present Illness: _____

Past Medical History / Problem List: _____

Date of Birth: _____ **Age:** _____ **Hospital of Birth:** _____

Gestational Age At Birth: Full Term Premature: _____ Weeks **Developmental Milestones Up To Date:** Yes No
If no, please explain: _____

Immunizations: Please attach copy if available. **Up To Date:** Yes No If no, please explain: _____

Congenital Problems: No Yes If yes, please explain: _____

Implanted Devices: No Yes If yes, please explain: _____

Sickle Cell Risk: Yes No

Past Surgical History: No Yes If yes, please explain: _____ **Prior Transfusion:** Yes No

Prior Anesthetic Problems: No Yes If yes , please explain: _____

Family History: _____

Mother: _____ **Father:** _____ **Siblings:** _____

Adopted: Yes No

Allergies: No Known Allergies **Medication(s)** No Yes If yes: _____

Medication	Manifestations	Medication	Manifestations

Latex Sensitive No Yes **Food Sensitivities** No Yes If yes please list: _____

Current Medications: (Include Herbs / Vitamins / Over The Counter) (Attach additional sheet if needed)

Medication/Indications	Dose	Route	Frequency	Date and Time of Last Dose

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REVIEW OF SYSTEMS: If not negative please elaborate.			
General: <input type="checkbox"/> Negative			
Neurologic: <input type="checkbox"/> Negative			
Hematologic: <input type="checkbox"/> Negative			
Pulmonary: <input type="checkbox"/> Negative			
Cardiac: <input type="checkbox"/> Negative			
Gastrointestinal: <input type="checkbox"/> Negative			
Renal / Urologic: <input type="checkbox"/> Negative			
Musculoskeletal: <input type="checkbox"/> Negative			
Endocrine: <input type="checkbox"/> Negative			
Reproductive: (For Females of Menarche): <input type="checkbox"/> Gravida: <input type="checkbox"/> Parity: Last menstrual period:			
PHYSICAL EXAMINATION: Please Describe All Abnormal Findings			
Vital Signs	Height / Length: Centimeters	Weight : Kilograms	Head Circumference: Centimeters
Temperature: °C	Heart Rate:	Respiratory Rate:	Blood Pressure: /
HEENT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
LUNGS	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
CARDIOVASCULAR	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
ABDOMEN	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
EXTREMITIES / PULSES	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
SKIN	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
NEUROLOGIC / MENTAL STATUS	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
SPINE	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
GENITAL	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
RECTAL	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:		
Additional Physical Exam Findings / Comments:			
Medical Assessment:			
Plan of Care:			
Evaluator:			
(Print Name):		Signature:	MD DO PA NP Beeper #:
<input type="checkbox"/> There have not been any changes in the history and examination			
<input type="checkbox"/> There have been changes in the history and examination:			
Admitting Attending			
Print Name:		Signature:	Date: / / Time: