



North Shore LIJ

Steven & Alexandra Cohen
Children's Medical
Center of NY

**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 for Use	Dose	Route	Frequency	Date and Time of Last Dose



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PRE - SURGICAL MEDICAL HISTORY / PHYSICAL EXAM

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:	Title: 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:			
Pressure Ulcer Present On Admission: <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, Site(s) / Description: _____			
Infection Present On Admission: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: _____			
Urinary Catheter Present On Admission: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Central Line(s) Present ON Admission <input type="checkbox"/> No <input type="checkbox"/> Yes If yes:			
Admitting Attending Physician			
Name Print:		Signature:	Date: / / Time: