

PRE-OPERATIVE PHYSICAL

TO BE COMPLETED BY PATIENT'S PEDIATRICIAN OR FAMILY PHYSICIAN

Patient Name: _____ Birth date: _____

Age: _____ Gender: M F

Date of H&P Exam: _____ Date of surgery: _____

Current Medications: _____

Operative Procedure: _____

Past Medical History:

Childhood Illnesses: _____

Allergies: _____

Surgeries: _____

Family History: _____

Social History: _____

Medical History:

Height: _____ Weight: _____ BP: _____

Temp: _____ Pulse: _____ Resp: _____

Please place a check mark if within normal limits:

_____ Neurologic _____ Lungs _____ Head _____ Neck

_____ Abdomen _____ Heart _____ Musculoskeletal _____ Skin

Please describe any conditions that fall outside of normal limits: _____

Patient's health satisfactory for general anesthetic? YES NO

Physician's Signature: _____

Physician's Name (printed): _____