dayton children's

PRE-SURGICAL HISTORY & PHYSICAL

Patient Name _____

Date of Birth _____

PLEASE FAX TO DCH SURGICAL SERVICES (937) 641-6420. GIVE A COPY TO PARENT

PLANNED PROCEDURE: Date of surgery:_____

INDICATION FOR SURGERY: _____

PREOPERATIVE HISTORY

Medical: _____
Surgical: _____
Recent illnesses: _____
System review: _____
Relevant family history: _____
Anesthesia/sedation problems: _____
Coagulation problem: _____
Allergies: _____
Current medications: _____

PHYSICAL: WT kg HT cm VS: T P_____ R_____ BP _____

HEENT:
Cardiovascular:_____
Respiratory: _____
Abdomen:_____
Musculoskeletal: _____
Neurological: _____
Other: _____

COMMENTS:_____

ASSESSMENT: _____

Signature: Date: Time:_____

MEDICAL RECORD