Cincinnati Children's Hospital Medical Center

PRE-PROCEDURE PHYSICAL EXAM FORM

Burnet Campus FAX # 513 636-3955
Liberty Campus FAX # 513 803-9941

Name: _____

DOB: _____

The child must be examined and the history and physical examination must be documented within thirty (30) days prior to a surgical procedure by a state licensed clinician.

Date of exam: _____ Date of surgery: _____ Surgeon: _____

Surgical procedure: _____

Site: _____ Side: ☐ Left ☐ Right ☐ Bilateral (If applicable)

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:	☐	☐	
Steroids past 6 months:	☐	☐	
Previous anesthesia:	☐	☐	
Recent infection/exposure:	☐	☐	
Immunizations needed:	☐	☐	
Seizures:	☐	☐	
Croup/wheezing:	☐	☐	
Bleeding tendency: Patient:	☐	☐	
Family:	☐	☐	

PHYSICAL EXAMINATION
Ht _____cm Wt _____kg Temp _____°C Pulse _____ BP_____ / _____

	NL	ABNL	Comments
Appearance:	☐	☐	
Skin/lymph:	☐	☐	
Head, eyes, ears, nose, throat:	☐	☐	
Teeth:	☐	☐	
Heart:	☐	☐	
Lungs:	☐	☐	
Abdominal:	☐	☐	
Genitalia:	☐	☐	
Extremity:	☐	☐	
Neurologic:	☐	☐	

Special Instructions: _____

_____

_____

Physician/Clinician Signature & Credentials Time Date

I have reviewed the above history and physical, the patient has been re-examined on the day of surgery, and I will proceed with the procedure.

Additional comments: _____

_____

_____

Surgeon/Proceduralist Signature & Credentials Time Date