



**PRE-PROCEDURE  
PHYSICAL EXAM FORM**  
FAX # 513 636-3955

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: \_\_\_\_\_

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:	<input type="checkbox"/>	<input type="checkbox"/>	
Steroids past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	
Previous anesthesia:	<input type="checkbox"/>	<input type="checkbox"/>	
Recent infection/exposure:	<input type="checkbox"/>	<input type="checkbox"/>	
Immunizations needed:	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures:	<input type="checkbox"/>	<input type="checkbox"/>	
Croup/wheezing:	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding tendency: Patient:	<input type="checkbox"/>	<input type="checkbox"/>	
Family:	<input type="checkbox"/>	<input type="checkbox"/>	

**PHYSICAL EXAMINATION**

Ht \_\_\_\_\_ cm    Wt \_\_\_\_\_ kg    Temp \_\_\_\_\_ °C    Pulse \_\_\_\_\_    BP \_\_\_\_\_ / \_\_\_\_\_

	NL	ABNL	Comments
Appearance:	<input type="checkbox"/>	<input type="checkbox"/>	
Skin/lymph:	<input type="checkbox"/>	<input type="checkbox"/>	
Head, eyes, ears, nose, throat:	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth:	<input type="checkbox"/>	<input type="checkbox"/>	
Heart:	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs:	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal:	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia:	<input type="checkbox"/>	<input type="checkbox"/>	
Extremity:	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic:	<input type="checkbox"/>	<input type="checkbox"/>	

Special Instructions: \_\_\_\_\_

Physician/Clinician Signature & Credentials \_\_\_\_\_

I have reviewed the above history and physical and will proceed with the procedure.

Additional comments: \_\_\_\_\_

Surgeon/Proceduralist Signature & Credentials \_\_\_\_\_

