White Plains Hospital

DAVIS AVENUE AT EAST POST ROAD • WHITE PLAINS, NY 10601

PEDIATRIC PRE-PROCEDURE HISTORY AND PHYSICAL

PATIENT LABEL / IDENTIFICATION

DATE:_____ **PATIENT NAME** _____

DOB: _____ **MALE** _____ **FEMALE** _____ **HT.**_____ **WT.** _____

CHIEF COMPLAINT: _____

HX OF PRESENT ILLNESS: _____

_____

CURRENT MEDICATIONS: _____ **ALLERGIES:**_____

OVER THE COUNTER/ HERBAL: _____ _____

PAST MEDICAL HISTORY: _____

HOSPITALIZATIONS: _____

SURGERY: _____

SERIOUS ILLNESS: _____

ANESTHESIA HISTORY: _____

RISK FACTORS FOR ANESTHESIA: _____

LMP:(FEMALES) ___ _____ **IMMUNIZATIONS: UP TO DATE YES**_____ **NO** _____ **(Attach Copy)**

REVIEW OF SYSTEMS: (CHECK IF NEGATIVE)

	Neg		Neg	COMMENTS
HEARING	____	CARDIAC	____	_____
VISION	____	SKIN	____	_____
ENT	____	ORTHOPEDIC	____	_____
ASTHMA	____	NEURO	____	_____
GI	____	GU	____	_____

FAMILY HX:	AGE	PROBLEM
Father	_____	_____
Mother	_____	_____
Sibling M/F	_____	_____
Sibling M/F	_____	_____
Sibling M/F	_____	_____

SOCIAL HISTORY:

LIVES WITH_____

_____

SCHOOL _____

_____

SMOKING / ALCOHOL / DRUGS_____

_____

PHYSICAL EXAM:

VITAL SIGNS: T_____**PULSE**_____**RESP**_____**BP**_____/ _____ **HEAD CIRC(2 AND UNDER)** _____

EYES_____**EARS**_____**NOSE**_____**THROAT**_____**SKIN**_____**NODES**_____

CHEST_____ **HEART** _____

ABD _____ **GU** _____

EXT_____ **NEURO** _____

IMPRESSION: _____ **CLEARED FOR PROCEDURE: Y**___ **N**___

PLAN: _____

PHYSICIANS SIGNATURE: _____**DATE:**_____ **TIME:**_____

ADDRESS: _____**PHONE:**_____

FAX TO WHITE PLAINS HOSPITAL CHART REVIEW # (914) 681-2936 **PLEASE ATTACH IMMUNIZATION RECORDS**

PHONE (914) 681-2144

WHP