New York Eye and Ear Infirmary of Mount Sinai

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Web Form

Patient Name
Date of Birth
Physician Name

PEDIATRIC MEDICAL ASSESSMENT
HISTORY + PHYSICAL EXAMINATION

Diagnosis: _____ Planned Procedure: _____ Date of Surgery: _____

PRESENT AND RECENT ILLNESS:

Medications: _____

Allergies: _____

Immunizations: Up to Date ☐ Yes ☐ No Explain: _____

MEDICAL SURGICAL HISTORY	Y	N	DETAILS OF POSITIVE RESPONSES
1. PREVIOUS SURGERY/HOSPITALIZATION			
2. PAST ANESTHESIA HISTORY			
3. PREMATURITY (Gestational age, Birth weight, Ventilation, Apnea, Prolonged intubation, Trach.)			
4. RESPIRATORY (e.g., Snoring, Apnea, Croup, Asthma)			
5. CARDIOVASCULAR (e.g., Heart Murmur, HTN, CHD)			
6. GI (Reflux)			
7. RENAL/URINARY			
8. HEMATOLOGIC/ONCOL (e.g., Bleeding, Transfusions, Chemo/RT)			
9. ENDOCRINE/METABOLIC			
10. NEURO/SEIZURE			
11. OTHER			

_____ lbs. _____ in.

Wt: _____ kg. Ht: _____ cm. BP: _____ / _____ HR: _____ T: _____ °F RR: _____

PHYSICAL EXAM:

Physical Appearance: _____

HEENT: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Mental Status: _____

Other: _____

Laboratory Results ☐ N/A ☐ CBC ☐ UA ☐ Other _____

Cleared for Anesthesia / Surgery / Special Procedure: ☐ Yes ☐ No ☐ N/A

Examiner's Name (Printed)	License #	Date	Time
Examiner's Address		Telephone #	
Examiner's Signature		Date	Time

Surgeon's Review: I have reviewed the attached documented history and physical examination and have reevaluated and reexamined the patient. Except for any changes or findings listed below, I certify that the patient's history, physical findings and condition are materially unchanged:

_____

_____

Attending Surgeon Signature: _____ Print Name: _____ Date: _____ Time: _____