Advanced Specialty
ANESTHESIA

HISTORY AND PHYSICAL

Patient Name: _____ DOB:_____

Informant:_____ Relationship_____

Date___/___/___ Time: _____hours/minutes

Primary Care Physician: _____ Referring Hospital/Physician:_____

Chief Complaint: _____

History of Present Illness: _____

_____

Past Medical/Surgical History: _____

_____

_____

REVIEW OF SYSTEMS

	See HPI	Negative
HEENT: _____	☐	☐
Pulmonary: _____	☐	☐
Cardiovascular: _____	☐	☐
Gastrointestinal: _____	☐	☐
Genitourinary/Reproductive: LMP ___/___/_____ Premenarchal	☐	☐
Bone/Skin/Joint: _____	☐	☐
Neurologic: _____	☐	☐
Endocrine: _____	☐	☐
Psychiatric: _____	☐	☐
Smoking/Drugs/Alcohol Use/Abuse: _____	☐	☐

Allergies: NKA ☐

Food allergies/ reaction: _____

Patient Name: _____ DOB:_____

Food allergies/ reaction: _____
Medication allergies/ reaction: _____
Medication allergies/reaction: _____

Medications/Herbal Preparations/Dietary Supplements: _____
_____
_____
_____

PHYSICAL EXAM

Wt: _____kg Ht: _____in Birth Weight: _____ T:_____°F P: _____ R:_____ BP: ____/____
General: _____
HEENT: _____Tonsils:_____
Neck/Lymphatics: _____
Gastrointestinal: _____
Respiratory: _____
Cardiovascular/Pulses: _____
Extremities: _____
Skin: _____
Neurological: _____
Other: _____
Laboratory/Radiology/Ancillary Results: _____
_____
_____
Assessment/Plan: _____
_____
_____
Child cleared for in office IV sedation YES _____ NO _____

Provider Signature/Title: _____ Date: _____
Provider Printed Name: _____
Practice Location: _____