Eastern Health

Janeway Pediatric Dentistry
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dentistry@easternhealth.ca

Please have the History and Physical form attached completed by a Physician and bring it with you to your OR appointment.

The History and Physical expires two months after it is completed.

If you have any questions or concerns please feel free to contact me.

Thank you,

Janelle Clarke

Janeway Children's Health & Rehabilitation Centre

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Eastern Health

Child/Women's Health Program

Pediatric Elective Surgery Outpatient/Same Day Admission History and Physical Record (Part I)

MS1210 2262 10 2017

Name:

HCN:

Date of Birth:

Allergies: ☐ Latex ☐ **No Known**

Diagnosis:

Surgical Procedures:

History of Present Illness: ☐ See clinic note from Specialty Clinic dated DD/MONTH/YYYY

Past Medical History (PMHx): (Check appropriate box)

The child has or has had;	YES	NO
Previous Surgery/Anesthetic	☐	☐
Previous Admission to Hospital	☐	☐
Respiratory Disease (e.g. Asthma, CLD)	☐	☐
Regular loud snoring or Sleep apnea	☐	☐
Heart disease (Including Congenital)	☐	☐
Hypertension	☐	☐
Diabetes	☐	☐
Other Endocrine Disorders	☐	☐
Kidney disorder	☐	☐
Metabolic Disorder	☐	☐
Reflux	☐	☐
Bleeding/Clotting Disorders	☐	☐
Neuro/muscular or Seizure Disorder	☐	☐
Parent/caregiver concern about child's emotional/behavioural reaction to surgery	☐	☐
Anxiety/Agitation (Sedation consideration)	☐	☐

PMHx: Selection details **AND** other conditions not listed.

(Extra information on reverse side: ☐ Yes ☐ No)

Medications: HealtheNL Reviewed: ☐ Yes ☐ No

(Extra information on reverse side: ☐ Yes ☐ No)

Family History:

Anesthetic problem/reaction ☐ Yes ☐ No

Bleeding/Clotting disorder ☐ Yes ☐ No

(Extra information on reverse side: ☐ Yes ☐ No)

Physical Examination: Weight: _____Kg General appearance: _____

Head/eyes/ears/nose/throat: _____

Respiratory: _____

Cardiac: _____

Gastrointestinal: _____

Genitourinary: _____

Musculoskeletal: _____

Neurology: _____

Other: _____

Name: _____ Signature: _____ Date: DD/MONTH/YYYY

Day of Surgery Review:

History and Physical changes since completion: ☐ Yes ☐ No Infection/Unwell in the past 2 weeks: ☐ Yes ☐ No

History and Physical greater than 3 months: ☐ Yes ☐ No Surgical site concern (e.g. rash/infection): ☐ Yes ☐ No

If "Yes" selected for any of the above, the patient must be reviewed and the Update section (reverse side) completed by the physician (or designate) preoperatively.

Name: _____ Signature: _____ Date: DD/MONTH/YYYY