

Janeway Pediatric Dentistry 300 Prince Philip Drive St. John's, NL Canada A1B 3V6 T:709-777-4353 F:709-777-4171 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,

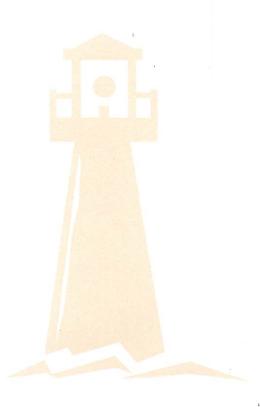
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## Pediatric Elective Surgery Outpatient/Same Day Admission History and Physical Record (Part I)

Name.

HCN:

Child/Women's Health Program



Date of Birth

Allergies: □ Latex □ No Known			
Diagnosis:		Surgical Procedures:	
History of Present Illness: ☐ See clinic note	e fro	om	Specialty Clinic dated DD/MONTH/YYYY
Past Medical History (PMHx): (Check a	anp	ropriate box)	PMHx: Selection details AND other conditions not listed.
<b>,</b> ,	ES		FINITY. Selection details AND other conditions not listed.
D			
Respiratory Disease (e.g. Asthma, CLD)			
Regular loud snoring or Sleep apnea			
			(Extra information on reverse side: $\square$ Yes $\square$ No)
			Medications: HealtheNL Reviewed: ☐ Yes ☐ No
District.			
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			(Extra information on reverse side: ☐ Yes ☐ No)
			Family History:
Parent/caregiver concern about child's			
emotional/behavioural reaction to surgery			Anesthetic problem/reaction
Anxiety/Agitation (Sedation consideration)			Bleeding/Clotting disorder $\square$ Yes $\square$ No (Extra information on reverse side: $\square$ Yes $\square$ No)
Physical Examination: Weight:	Kg	Genera	al appearance:
Head/eyes/ears/nose/throat:			
Respiratory:			
Cardiac:			
Gastrointestinal:			
Genitourinary:			
Musculoskeletal:			
Neurology:			
Other:	_		
			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: Sig	gna	ature:	Date: DD/MONTH/YYYY