# Pre Op History and Physical Form
## Mercy Clinic Children's Urology
Fax 314-251-6998

**Patient Name:** _____ **DOB:** _____

**PLEASE DO NOT ADMINISTER IMMUNIZATIONS, VACCINATIONS AND FLU SHOTS 7 DAYS PRIOR TO THE SURGERY DATE**

Chief Complaint: _____

_____

Present Illness: _____

_____

Past Medical / Surgical History: _____

_____

Social / Family History: _____

Vital Signs: W _____ B/P _____ P _____ R _____ T _____ ASA Status _____

Medications: _____

Allergies: _____

| REVIEW OF SYSTEMS | NEG | COMMENTS |
|---|---|---|
| Constitutional (fever, wt. change, etc.) | | |
| Sedation/Anesthesia Problems | | |
| HEENT | | |
| GI | | |
| Neuro | | |
| Endocrine | | |
| Musculoskeletal | | |
| Cardiopulmonary | | |
| Genitourinary | | |
| Hematologic | | |
| Other | | |
| **PHYSICAL EXAMINATION** | **WNL** | **ABNORMAL (SPECIFY)** |
| General Appearance | | |
| Head - Eyes - Ears | | |
| Upper Airway | | |
| Neck - Back | | |
| Abdomen | | |
| Skin - Nodes | | |
| Extremities | | |
| Neuro | | |
| Heart - Lungs | | |
| Chest - Breasts | | |
| Pelvis - Rectum | | |

**Diagnostic Studies:** _____

**Diagnosis (Impression):** _____

**Plan of Care:** _____

**Cleared for Sedation:** Yes No N/A

**Physician's Signature:** _____ **Date:** _____