Franciscan Children's
So every kid can.

30 Warren Street
Brighton, MA 02135

Please Fax To: _____

PREOPERATIVE HISTORY AND PHYSICAL EXAMINATION

(Must be completed no more than 60 days in advance and no later than 2 weeks prior to the procedure)

Patient Name: _____ **DOB:** _____

Medical History	Medications
Family History	Allergies
Previous General Anesthesia ☐ Yes ☐ No Complications with Anesthesia ☐ Yes ☐ No Family HX of ANES Complications ☐ Yes ☐ No If Yes Describe:	Indicated Laboratory Data
Date of Exam: _____ HT WT T P R BP Heent Airway Neck Heart Chest Abdomen Extremities Neuro Skin	ROS Problem List

Physician's Signature _____

PLEASE PRINT YOUR CONTACT INFORMATION TO ENSURE YOU RECEIVE A COPY OF THE OPERATIVE REPORT.

Name _____ Tel: _____

Address _____