



Children's
of Alabama

Name: _____

DOB: _____ MR# _____

Test Date: _____

Fax: _____

**ONE DAY SURGERY CENTER
HISTORY AND PHYSICAL EXAMINATION**

Chief Complaint _____

Other: _____

Pertinent Medical History: _____

Drug/Food Sensitivities and Allergies: _____

Immunizations: _____ Medications: _____

Does the mother breastfeed the infant/child? () Yes () No

If Yes, What medications is the mother taking? _____

Bleeding Tendency: _____

Family Anesthesia History: _____

Social Development/History: _____

PHYSICAL EXAMINATION:

HEENT (loose teeth): _____

Heart: _____

Lungs: _____

Abdomen: _____

Other: _____

IMPRESSION: _____

REMARKS: _____

Signature

Date

Time

Attending Physician Signature

Date

Time