Reset

New York Eye and Ear Infirmary of Mount Sinai

310 East 14th Street
New York, NY 10003
Tel: (212) 979-4306

Patient Name: _____

Date of Birth: _____

Admission Date: _____

Admitting Physician *(FULL NAME W/MIDDLE INITIAL):*

Preferred Language ☐ English ☐ Chinese ☐ Mandarin ☐ Cantonese ☐ Spanish ☐ Russian ☐ Other: _____

PEDIATRIC MEDICAL EVALUATION

Diagnosis: Planned Procedure: Date of Surgery:

PRESENT AND RECENT ILLNESS:

Medications: _____

Allergies: _____

Immunizations: Up to Date ☐ Yes ☐ No Explain: _____

MEDICAL SURGICAL HISTORY	Y	N	DETAILS OF POSITIVE REPONSES
1. PREVIOUS SURGERY / HOSPITALIZATION			
2. PAST ANESTHESIA HISTORY			
3. PREMATURITY (Gestational age, Birth weight, Ventilation, Apnea, Prolonged intubation, Trach.)			
4. RESPIRATORY (e.g., Snoring, Apnea, Croup, Asthma)			
5. CARDIOVASCULAR (e.g., Heart Murmur, HTN, CHD)			
6. GI (Reflux)			
7. RENAL / URINARY			
8. HEMATOLOGIC / ONCOL (e.g., Bleeding, Transfusion, Chemo / RT)			
9. ENDOCRINE / METABOLIC			
10. NEURO / SEIZURE			
11. OTHER			

Wt: _____ kg. _____ lbs. HT: _____ cm. _____ in.

BP: _____ / _____ HR: _____ T: _____ °F RR: _____

PHYSICAL EXAM:

Physical Appearance: _____

HEENT: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Mental Status: _____

Other: _____

Laboratory Results ☐ N/A ☐ CBC ☐ UA ☐ Other: _____

Cleared for Anesthesia / Surgery / Special Procedure: ☐ Yes ☐ No ☐ N/A

Examiner's Name (Printed):	License #	
Examiner's Address:	Telephone #	
Examiner's Signature:	Date:	Time: