HISTORY & PHYSICAL FORM
FOR PRIMARY PROVIDER

Patient: _____

Procedure: _____

Date of Surgery: _____

EKG: Must be current to within 6 months of surgery

PATIENT HISTORY Please describe YES responses

Cardiac / Vascular	NO / YES	_____
Pulmonary	NO / YES	_____
Nephro	NO / YES	_____
Hepato	NO / YES	_____
Endocrine	NO / YES	_____
Diabetic	NO / YES	_____
	Insulin NO / YES	Oral Meds NO / YES
Neuromuscular	NO / YES	_____
Bleeding Tendency	NO / YES	_____
Recent Injuries or Accidents	NO / YES	_____
Previous Surgery & Anesthesia Complications ?	NO / YES	_____
Drug/Alcohol/Tobacco	NO / YES	_____

ALLERGIES Please describe YES responses

Medications	NO / YES	_____
Tape/X-Ray Prep	NO / YES	_____
Latex Sensitivity	NO / YES	_____

CURRENT MEDICATION - Prescription/OTC

_____

_____

_____

_____

LAB RESULTS * If applicable

*INR _____

*K _____

*Hgb/Other _____

VITAL SIGNS HT: _____ WT: _____ BMI: _____

T _____ P _____ R _____ BP _____

PHYSICAL EXAMINATION

	WML	ABN
Scalp / Skull	_____	_____
Neck	_____	_____
Eyes	_____	_____
Ears, Nose. Throat	_____	_____
Mouth, Teeth	_____	_____
Thyroid	_____	_____
Lymph Nodes	_____	_____
Chest	_____	_____
Heart	_____	_____
Lungs	_____	_____
Vascular	_____	_____
Abdomen	_____	_____
Kidneys	_____	_____
Skin	_____	_____
Extremities	_____	_____
Neurological	_____	_____
Other	_____	_____

COMMENTS AND/OR IMPRESSIONS

_____

_____

_____

_____

Is the patient a candidate for

Monitored Anesthesia Care? NO / YES

_____

_____

_____

_____ _____

Primary Care Providers Signature Date

Associated Eye Care

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