HISTORY AND PHYSICAL EXAM FOR OUTPATIENT SURGERY

Today's Date:_____
PATIENT NAME:_____DATE OF BIRTH:_____

CHIEF COMPLAINT:_____

HISTORY OF PRESENT ILLNESS:_____
_____

PAST MEDICAL HISTORY:
GENERAL HEALTH:_____
CHILDHOOD ILLNESS:_____
IMMUNIZATIONS:_____
PAST SURGICAL HISTORY:_____
FAMILY HISTORY:_____
MEDICATIONS:_____
ALLERGIES:_____

PHYSICAL EXAMINATION:

HEIGHT:_____WEIGHT:_____BP:_____/_____PULSE:_____RESP:_____
REVIEW SYSTEMS:
GENERAL:_____
VITALS:_____
SKIN:_____
HEAD:_____
EYES:_____
EARS:_____
NOSE:_____
MOUTH,THROAT:_____
NECK:_____
HEART:_____
LUNGS:_____
ABDOMEN:_____
GENITOURINARY:_____
RECTAL:_____
MUSCULOSKELETAL:_____
VASCULAR:_____
LYMPHATIC:_____
NEUROLOGIC:_____
HEMATOLOGIC:_____
ENDOCRINE:_____
PSYCHIATRIC:_____

PATIENT NAME:_____DATE OF BIRTH:_____

LABS:_____

ASSESSMENT/PLAN:_____

OTHER PERTINENT INFORMATION:_____

IS THIS PATIENT CLEARED FOR SURGERY AND GENERAL ANESTHESIA:

YES:_____ NO:_____

PHYSICIAN SIGNATURE:_____

PHYSICIAN PRINTED NAME:_____
Address:_____
Phone:_____

Date Exam Completed:_____

PLEASE FAX COMPLETED FORMS TO: 517.736.3806 (Coldwater Office) or
517.741.8912 (Union City Office)

Email: cwsurgery@ucsmiles.com (Coldwater) or hospital@ucsmiles.com

jg 06/29/2016