History & Physical Form

Patient Name:____ **Date of Birth**_________________________

Surgeon____ **Procedure Date**______________________

Scheduled Procedure____

Reason for Visit

Significant Illness/Hospitalizations	**Surgeries/Procedures**

Current Medications (inc.OTC meds, Herbals and ASA)

Advance Directive: __Yes __No If Yes, Comment:

Allergies & Significant Side Effects (list reactions)

Immunizations are up to date: __Yes __No | **Oral steriod** use within 6 months: __Yes __No

Habits (Hx of Smoking) (ETOH, street drugs, HIV exposure, caffeine)

Family Hx (***Incl. Anesthesia Reactions):*** Cancer HTN

DM CVA MI TB

PATIENT DATA:

HEIGHT	**WEIGHT**	**TEMP**	**PULSE**	**RESP**	**B/P**
	LB/KG				

Lab: **K+**___________ (if on potassium depleting drug – must be drawn within 48 hours of surgery) **Hgb**______________

INR_________________ **Pregnancy Test** ________________ (for all women of child bearing age)

EKG: (if patient is 50 or older – regardless of cardiac history) ***(Must be read before surgery)***

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REVIEW OF SYSTEMS :
SKIN (site of surgery – rash/infection)
HEENT (migraines, sinusitis, contacts, dentures)
BREASTS
RESP (recent URI) (cough, wheeze, sputum, asthma, COPD, SOB)
CARDIOVASCULAR (SOB, CP, PND, edema, palpitations, CHF, HTN, MVP, MI)
GASTROINTESTINAL (reflux, ulcers)
GENITO-URINARY/OB/GYN (LMP, Contraception)
NEURO-PSYCH (depression, active psychosis)
MUSCULOSKELETAL (ROM limitation, previous surgery, fractures)
ENDOCRINE/EME/ONC (anemia, bleeding problems, thyroid, diabetes, cancer – chemo, radiation, steroids)
SOCIAL HX (occupation, family, insurance, sources of stress)

SUMMARY: List any contraindications to scheduled surgery.
PLAN: (Prophylaxis, if indicated; Meds to be taken a.m. of surgery,; Any problems anticipated from medical standpoint)

DATE/TIME	**PRINT NAME**	**SIGNATURE**

Please fax to North Metro Surgery Center:

Fax #763-755-6516 ***Phone #763-755-6540***

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