

FAX TO 904-564-3880

Current Date: _____ Current Time: _____
 NAME: _____ Male Female Patient DOB: _____
 PRINT PHYSICIAN'S NAME: _____ PROPOSED DATE OF SURGERY: _____
 HISTORY: Chief complaint/history of present illness: _____

PAST MEDICAL HISTORY:

Surgical: _____
 Medical: _____
 Allergies: _____
 Medications: _____
 Social History: _____
 Family History: _____

REVIEW OF SYSTEMS			VITAL SIGNS
Eyes: <input type="checkbox"/> Neg _____	ENT: <input type="checkbox"/> Neg _____	GI: <input type="checkbox"/> Neg _____	Pulse: _____
CV: <input type="checkbox"/> Neg _____	Resp: <input type="checkbox"/> Neg _____	Msk: <input type="checkbox"/> Neg _____	Temp: _____
GU: <input type="checkbox"/> Neg _____	Hematological: <input type="checkbox"/> Neg _____	Constitutional: <input type="checkbox"/> Neg _____	Respiration: _____
Neuro: <input type="checkbox"/> Neg _____	Psychiat: <input type="checkbox"/> Neg _____	Req Proc: <input type="checkbox"/> Neg _____	BP: _____
Integumentary: <input type="checkbox"/> Neg _____	Endo: <input type="checkbox"/> Neg _____		Height: _____
			Weight: _____

PHYSICAL

Physical Examination:

H.E.E.N.T.: _____ Neck: _____
 Heart: _____ Genital/Urinary Exam: _____
 Lungs: _____ Breast: _____
 Abdomen: _____
 Extremities: _____
 Impression: _____

PLAN OF ANESTHESIA	
Per Anesthesiologist	<input type="checkbox"/>
Local	<input type="checkbox"/>
Moderate Sedation	<input type="checkbox"/>
ASA Class I II III IV	
<i>(circle one)</i>	

PLAN: _____

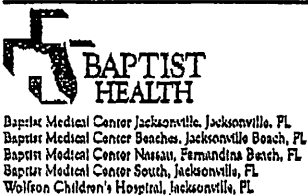
PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

PHYSICIAN SIGNATURE REQUIRED. EXTENDER SIGNATURE MUST BE CO-SIGNED BY MD.

HISTORY AND PHYSICAL UPDATE Date: _____ Time: _____

- Reviewed the charted History and Physical (performed within the last 30 days of admission or outpatient service), the patient was re-examined, and there were no changes in status.
- Reviewed the charted History and Physical (performed within the last 30 days of admission or outpatient service), the patient was re-examined, with change of status of: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____



OUTPATIENT HISTORY AND PHYSICAL



1153

PATIENT LABEL