

FAX TO 904-391-5611

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 (circle one)	

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: _____



Baptist Medical Center Jacksonville, Jacksonville, FL
 Baptist Medical Center Beach, Jacksonville Beach, FL
 Baptist Medical Center Nassau, Fernandina Beach, FL
 Baptist Medical Center South, Jacksonville, FL
 Wolfson Children's Hospital, Jacksonville, FL

OUTPATIENT HISTORY AND PHYSICAL



1153

PATIENT LABEL