PRE-OP PHYSICAL **FAX TO 904-398-3077 AND 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: ☐ Neg _____	ENT: ☐ Neg _____	GI: ☐ Neg _____	Pulse: _____
CV: ☐ Neg _____	Resp: ☐ Neg _____	Msk: ☐ Neg _____	Temp: _____
GU: ☐ Neg _____	Hematological: ☐ Neg	Constitutional: ☐ Neg	Respiration: _____
Neuro: ☐ Neg _____	_____	_____	BP: _____
Integumentary: ☐ Neg	Psychiat: ☐ Neg _____	Proc: ☐ Neg _____	Height: _____
_____	Endo: ☐ Neg _____		Weight: _____

PHYSICAL

Physical Examination:

H.E.E.N.T.: _____ Neck: _____

Heart: _____ Genital/Urinary Exam: _____

Lungs: _____ Breast: _____

Abdomen: _____

Extremities: _____

Impression: _____

PLAN: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

EXTENDER SIGNATURE: _____ DATE: _____ TIME: _____

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

BAPTIST HEALTH

Baptist Medical Center Jacksonville, Jacksonville, FL
Baptist Medical Center Beaches, 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

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PATIENT LABEL