

PRE-OP PHYSICAL | CENTER ONE SURGERY CENTER

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 _____	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: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

EXTENDER SIGNATURE: _____ DATE: _____ TIME: _____

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

FAX TO:

**ENT FOR KIDS 904-398-3077
AND
CENTER ONE SURGERY CENTER 904-564-3880**