PRE-OP PHYSICAL | PARKSIDE 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: ☐ 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.

FAX TO:

ENT FOR KIDS 904-398-3077
AND
PARKSIDE SURGERY CENTER 904-338-9016