

SURGICAL HISTORY AND PHYSICAL FORM

Patient Name _____ **Date** _____

Gender Male Female Birthday _____ Referring Physician _____

Reason for Visit _____

ALLERGIES: None (Please note reaction for each medication) **LATEX ALLERGY** YES NO

FOOD ALLERGIES: YES NO _____

DYES OR TAPE ALLERGIES: YES NO _____

SHELLFISH OR IODINE ALLERGIES: YES NO _____

CURRENT MEDICATIONS: Include dosage, instructions (once a day), and all over the counter drugs.

SEE HOME MEDICATION LIST

SOCIAL HISTORY: Single Married Divorced Widowed Advanced Directives YES NO

Occupation: _____

Smoker: YES NO Quit: _____ Packs per day: _____ Number of years smoked: _____

Alcohol: YES NO Drinks per day/week: _____

Drug Use or Addiction: YES NO Past – Quit: _____ Drug: _____

FAMILY HISTORY: none

Cancer Diabetes Heart Disease Respiratory Problems Other: _____

SURGICAL HISTORY: None Reported Please list surgery and approximate date

Implants / Devices (please list site of implant, ie. – left hip) _____

Surgery / Anesthesia-related Problems: NONE

Anesthesia Problems Malignant hyperthermia

Pain control / Pain medicine Family History of anesthesia problems

Other: _____

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Review of Systems (please check any and all that apply, adding comments if needed)		
Head and Neck	<input type="checkbox"/> None	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Jaw pain or clicking <input type="checkbox"/> problems opening mouth wide, turning head <input type="checkbox"/> SLEEP APNEA <input type="checkbox"/> Dentures / Partials / Crowns
Cardiovascular	<input type="checkbox"/> None	<input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Pacemaker / Implanted Defibrillator
Respiratory	<input type="checkbox"/> None	<input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough <input type="checkbox"/> Emphysema / COPD
Gastrointestinal	<input type="checkbox"/> None	<input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> GERD / Indigestion <input type="checkbox"/> Colitis / IBS / Crohn's <input type="checkbox"/> Liver Disease <input type="checkbox"/> Hepatitis-type _____ <input type="checkbox"/> Jaundice
Genitourinary / Reproductive	<input type="checkbox"/> None	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Renal Failure <input type="checkbox"/> Incontinence Men: <input type="checkbox"/> Prostate problems / drug use for enlarged prostate Women: <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Pregnant <input type="checkbox"/> N/A
Musculoskeletal	<input type="checkbox"/> None	<input type="checkbox"/> Muscle pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Physical Limitations / Weakness
Breast	<input type="checkbox"/> None	<input type="checkbox"/> Lumps / Masses <input type="checkbox"/> Breast Cancer right / left (circle) <input type="checkbox"/> Mastectomy right/ left (circle) <input type="checkbox"/> Lymph nodes taken
Neurologic	<input type="checkbox"/> None	<input type="checkbox"/> Stroke – any residual effect: _____ <input type="checkbox"/> Seizures <input type="checkbox"/> Migraines <input type="checkbox"/> Confusion
Psychiatric	<input type="checkbox"/> None	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Current Treatment <input type="checkbox"/> Other: _____
Endocrine / Metabolic	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes Insulin Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No Well Controlled <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Thyroid Disease
Hematologic Lymphatic Immunologic	<input type="checkbox"/> None	<input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blood Clots / DVT <input type="checkbox"/> Previous Blood Transfusions – date _____ <input type="checkbox"/> MRSA <input type="checkbox"/> Other: _____
Ocular	<input type="checkbox"/> None	<input type="checkbox"/> Cataract Surgery right/left <input type="checkbox"/> Glaucoma right/left <input type="checkbox"/> LASIK <input type="checkbox"/> Muscle Surgery right/left <input type="checkbox"/> Vitrectomy right/left <input type="checkbox"/> eye lid surgery right/left

FOR OFFICE USE ONLY:

Ophthalmic History <input type="checkbox"/> See Separate Sheet						
	Cornea	Lens	Disc	Macula	IOP	Other / VA
OD						
OS						
Other: _____						
Impression and Plan:						
Astigmatism Cataract Glaucoma Corneal Edema Corneal Scar Hyperopia Myopia Pterygium						
Patient has been examined by me. All risks, benefits and alternatives to surgery have been discussed with the patient/ family. All questions have been answered.						
Physician Signature: _____ Date _____ Time _____						