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History and Physical Form for Outpatient Surgery

Please fax us the completed form by a Medical Doctor as required by your surgical facility.
Keep a copy of the completed form and bring it with you day of surgery.

Name:_____ **Current Date**:____/____/____

Date of Birth:___/___/_____ MALE ☐ FEMALE ☐ **Proposed date of Surgery**:___/___/____

Current Medical History:

_____

_____

Medication Allergies: _____

Current Medications: _____

Past Medical History:

Surgical:_____

Medical:_____

Allergies (other):_____

Social History:_____

Family History:_____

Review of Systems:_____

_____

Physical Vital Signs:

Pulse:_____ Temperature:_____ Height:_____

Respiration:_____ Blood Pressure:_____Weight:_____

Physical Examination:

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

_____

Neck:_____Lungs:_____

Heart:_____Abdomen:_____

Extremities:_____Genital / Urinary Exam:_____

Neuro:_____Breast:_____

Impression:_____

_____

_____

_____

Plan:_____

_____

_____

_____

_____
DOCTOR/PROVIDER SIGNATURE

_____
PRINT DOCTOR/PROVIDER NAME

PATIENT LABEL