

HISTORY AND PHYSICAL FOR SURGERY
THIS FORM MUST BE FAXED TO 708.876.0175
PATIENT SHOULD BRING A COPY ON THE DAY OF SURGERY



Patient Name: _____ Date of Surgery: _____ Physician: _____

Date of Birth: _____ Present Illness/Chief Complaint: _____

Allergies: None Drug Seasonal General Specify: _____

Previous Hospitalizations / Surgical Procedures: _____

Present Medications: (include dose and frequency): _____

(CHECK IF APPLIES TO PATIENT)

- Hypertension Cardiac Respiratory Gastrointestinal Tobacco Genitourinary Hepatic
 Diabetes Alcohol Seizure Disorder Hematologic Thyroid ENT/Airway
 Musculoskeletal Recreational Drugs

Additional information: _____

Family History: _____

Height: _____

Weight: _____

| PHYSICAL EXAMINATION | NEGATIVE | POSITIVE FINDINGS |
|----------------------------|----------|-------------------|
| GENERAL | | |
| SKIN | | |
| EENT | | |
| RESPIRATORY | | |
| CARDIO/PERIPHERAL VASCULAR | | |
| RHYTHM/MURMURS | | |
| EDEMA / PULSES | | |
| ABDOMEN: BOWEL SOUNDS | | |
| TENDERNESS | | |
| LIVER | | |
| SPLEEN | | |
| KIDNEY | | |
| BLADDER | | |
| GYNECOLOGICAL | | |
| RECTAL | | |
| LOCOMOTOR | | |
| NEURO PSYCHIATRIC | | |

Impression: _____

Plan: Cleared for ocular surgery _____

Physician Signature: _____ Date/Time: _____

[] See Long Form Physical Examination or Other Physician History & Physical Valid for 30 days
IF THIS FORM IS NOT FAXED AT LEAST 48 HOURS PRIOR TO SURGERY THE SURGERY MAY BE CANCELLED
SURGERY DEPARTMENT F: 708.876.0175

CHICAGO RIDGE
10436 Southwest Hwy
Chicago Ridge, IL 60415

TINLEY PARK
18210 S. LaGrange Rd., Ste 210
Tinley Park, IL 60487
708.873.0088

MUNSTER
9610 N Centennial Dr. St H
Munster, IN 46321