HISTORY AND PHYSICAL FOR SURGERY

PATIENT SHOULD BRING A COPY ON THE DAY OF SURGERY

Please fax this History and Physical form to 708.952.0329

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 ☐ 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 PHYCHIATRIC		

Impression: _____

Plan: ☐ **Cleared for ocular surgery** ☐ _____

Physician Signature: _____ Date/Time: _____

Valid for 30 days

IF THIS FORM IS NOT FAXED AT LEAST 48 HOURS PRIOR TO SURGERY THE SURGERY MAY BE CANCELLED

TICHO EYE ASSOCIATES

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