

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



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

Social History/ Additional information: _____
 Family/Social 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		
LOCOMOTOR		
NEURO PSHYCHIATRIC		

CLEARED FOR OCULAR SURGERY ☐ _____

SENT FOR ADDITIONAL CLEARANCES ☐ _____

Physician Signature: _____ Date/Time: _____

THIS FORM MUST BE FAXED AT LEAST TWO WEEKS PRIOR TO SURGERY
SURGERY DEPARTMENT FAX: 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
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 Munster, IN 46321