PLEASE NOTE: THIS FORM MUST BE COMPLETED AND RETURNED WITHIN 30 DAYS OF THE SURGERY DATE

Admitting MD	NAME:
Diagnosis	Date of Procedure

PROPOSED PROCEDURE (if applicable)

HISTORY – PRESENT COMPLAINT

Current Medications

PAST MEDICAL HISTORY	**FAMILY HISTORY**	**SOCIAL HISTORY**
Allergies: ☐ Yes ☐No Previous Surgery/Hospitalizations: ☐ Yes ☐No Immunizations Up to Date: ☐ Yes ☐No	Anest. Rxn.: ☐ Yes ☐No Bleeding: ☐ Yes ☐No Other Pertinent:	Pertinent ☐ Yes ☐No

PHYSICAL EXAMINATION

HEIGHT ______________ **cm** **WEIGHT** __________________ **kg**

R.O.S. – **any problems noted on reverse side**		**SYSTEM**		Examined and WNL	Examined and Not WNL	Exam Deferred	Abnormalities/deferment explained here by system number
1	☐	1. Eyes	1	☐	☐	☐	
2	☐	2.. Ears, nose, mouth	2	☐	☐	☐	
3	☐	3. Cardiovascular	3	☐	☐	☐	
4	☐	4. Respiratory	4	☐	☐	☐	
5	☐	5. Gastrointestinal	5	☐	☐	☐	
6	☐	6. Genitourinary	6	☐	☐	☐	
7	☐	7. Musculoskeletal	7	☐	☐	☐	
8	☐	8. Skin	8	☐	☐	☐	
9	☐	9. Neurologic	9	☐	☐	☐	
10	☐	10.Psychiatric	10	☐	☐	☐	
11	☐	11.Hematologic/Lymphatic	11	☐	☐	☐	
12	☐	12.Other	12	☐	☐	☐	

LABORATORY **Hgb/Hct: (if applicable)** **Other:**	**MD Signature**________________________________ **Date**_______________ **Time**_________________

DO NOT WRITE BELOW – FOR DAY OF SURGERY/PROCEDURE ONLY

Patient has been examined – H&P reviewed – No changes ☐

Patient has been examined – H&P reviewed – Changes noted below:

____

MD Signature _________________________________ ***Date*** _____________ ***Time*** _____________