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 Suite 102, Cincinnati, OH 45236
 (513) 793-6011

HISTORY & PHYSICAL

PLEASE FAX TO: (513) 793-6099

PATIENT: _____ SEX: M or F DATE OF SURGERY: ____/____/____

DOB: ____/____/____ AGE: _____ WEIGHT: _____ HEIGHT: _____ SURGEON _____

INDICATOR(S): SYMPTOM(S) FOR PROCEDURE(S): _____

REACTION TO MEDICATION / ALLERGIES: _____

CURRENT MEDICATION / DOSAGES: _____

PAST SIGNIFICANT MEDICAL / ANESTHESIA HISTORY: _____

PAST SURGICAL HISTORY: _____

ANY PROBLEMS W / ANESTHESIA? IF SO WHAT? _____

PHYSICAL EXAMINATION

NORMAL ABNORMAL

HEENT
 HEART
 LUNGS
 ABDOMEN
 EXTREMITIES

REVIEW OF SYMPTOMS / PERTINENT POSITIVES:

TEMP: _____ BLOOD PRESSURE: _____ PULSE: _____ RESP: _____

PRE-OP LAB GUIDELINES: PLEASE USE YOUR DISCRETION IN THE ORDERING OF THE FOLLOWING TESTS:

- PATIENT ON DIURETIC: K+ LEVEL
- PATIENT ON ANTICOAGULANTS: PT/PTT STABLE LEVEL
- EKG: AGE 65 & OVER; GOOD FOR 1 YEAR UNLESS CARDIAC HISTORY, THEN 30 DAYS

PATIENT APPROVED FOR SURGERY AT AN OUTPATIENT SURGICAL CENTER WITH POSSIBILITY OF GENERAL / ENDOTRACHEAL ANESTHESIA: YES or NO

ALL MEDICAL CONDITIONS ARE CURRENTLY STABLE: YES or NO

PHYSICIAN'S PRINTED NAME: _____

PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/____