

Print or Type Information

Patient's Full Name _____

Date of Birth _____

HISTORY AND PHYSICAL

See Attached H & P

Indication for Procedure:

History and/or comorbid condition:

Physical Evaluation:

	Normal	COMMENTS:
Heart	_____	_____
Lungs	_____	_____
Abdomen	_____	_____
Neuromuscular	_____	_____

	Excellent	Good	Fair	Poor
General Physical Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Physician's Signature _____ Date _____

(not required if H & P is attached)

Medication: _____ Dosage: _____

Allergies or Adverse Drug Reactions:

Mental Status Oriented Disoriented

Comments: _____

Physician H & P Update:

(Required if H & P date is prior to surgery date)

No change(s) from previous H & P

ASA Class 1 2 3 (For LOCAL Anesthetic patients ONLY)

Physician's Signature _____ Date _____

Physician's Orders:
