

HISTORY AND PHYSICAL EVALUATION FORM

This form must be completed by your physician ***WITHIN 30 DAYS*** of your scheduled procedure and ***FAXED*** to Liberty Surgical Center at 215-673-9236 ***10 DAYS PRIOR TO THE PROCEDURE*** or surgery will be postponed. (Pennsylvania DOH regulation states this form may not be greater than 30 days)

DATE OF SURGERY: _____ **SURGEON'S NAME** _____

Please submit an ***EKG with interpretation and physician signature that was completed within 12 months of scheduled procedure for ALL patients 70 years and older.*** An EKG is also required for patients under the age of 70 who have cardiac disease. (Ischemia, CHF, Arrhythmias, Stroke, ICD/pacemaker)

Patient Name: _____ Date of Birth: _____

Pre-op Diagnosis: _____ Proposed Surgery: _____

Allergies / Reaction: _____

Medications/Dosages: _____

Indications for Surgery: _____

Past **MEDICAL** History (including pulmonary, cardiac history and psych) _____

Past **SURGICAL** History _____

EKG: Normal
 Abnormal, no change from prior EKG **COMMENTS:** _____

Physical Examination/Findings

HT: _____ WT: _____ lbs AGE: _____ yrs **SEX:** M / F **Vitals:** BP: _____ HR: _____

General Appearance: _____

Please check the boxes if there are no significant findings and describe **ABNORMAL** findings.

<input type="checkbox"/> HEENT _____	<input type="checkbox"/> LUNGS _____
<input type="checkbox"/> HEART _____	<input type="checkbox"/> GI/ABD _____
<input type="checkbox"/> GU _____	<input type="checkbox"/> MUSC/SKEL _____
<input type="checkbox"/> EXT _____	<input type="checkbox"/> NEURO _____

After examining the patient and reviewing the preoperative data, I find this patient to be medically stable for the proposed surgery. It is the surgeon's intention to perform proposed surgery in an ambulatory setting.

Signature _____ M.D./D.O. Date _____

Printed Name _____ Phone# _____

No Interval Changes since H & P _____ MD/DO _____

Surgeon Signature

Date