



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 6 months of scheduled procedure for ALL patients 60 years and older. An EKG is also required for patients under the age of 60 who have cardiac disease.

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