Patient Identification

Pre-operative History and Physical Examination

Note: to be completed by patient's primary care physician.

Patient Name: _____

Date of Surgery: _____ Surgeon(s): _____
month/day/year

Proposed surgery: _____

Allergies: _____ Medications: _____
name and dosage

Past medical and surgical history: _____

Functional Inquiry:

	Normal	If Abnormal, describe
Neurological	□	
Cardiovascular	□	for significant heart disease, please attach recent EKG
Respiratory	□	
Gastrointestinal	□	
Genitourinary	□	
Endocrine	□	
Hematological	□	
Musculoskeltal	□	

Physical Examination:

Heart Rate:	Respiratory Rate:	Blood Pressure:	Height (cm):	Weight (kg):

System	Normal	Abnormal	System	Normal	Abnormal
General	□	□	Head, Eyes, Ears, Nose, and Throat	□	□
Neck	□	□	Abdomen	□	□
Lungs	□	□	Musculoskeletal	□	□
Heart	□	□	Neurological	□	□
			Skin and Hair	□	□

Describe Abnormalities: _____
_____

Impression: _____
_____

Date: _____ Time: _____ PRINT Name: _____MD
Month/Day/Year HH:MM

MD Phone: _____ MD Fax: _____ Signature: _____MD