

Surgery History and Physical

PATIENT NAME: _____ DOB: _____

DATE OF ADMISSION/SERVICE _____ Acct. _____

DIAGNOSIS _____ PROCEDURE: _____

DATE OF SURGERY _____ AGE _____ HT _____ WT _____ BP _____ T/P/R _____ LMP _____

II. PAST MEDICAL HISTORY:	NO	YES	IF YES, SPECIFY
A. HOSPITALIZATIONS	_____	_____	_____
B. MEDICATIONS	_____	_____	_____
C. ALLERGIES	_____	_____	_____
D. SBE PROPHYLAXIS	_____	_____	_____

III. PAST SURGICAL HISTORY _____

IV. SOCIAL HISTORY:

A. USE OF ALCOHOL	_____	_____	_____
B. USE OF TOBACCO	_____	_____	_____
C. USE OF DRUGS	_____	_____	_____

V. FAMILY HISTORY OF:

A. ANESTHESIA PROBLEMS	_____	_____	_____
B. BLEEDING DISORDERS	_____	_____	_____
D. OTHER	_____	_____	_____

VI. HISTORY/PHYSICAL EXAMINATION: _____

GENERAL APPEARANCE : _____

HEENT: _____

NECK: _____

LUNGS: _____

CARDIAC: _____

ABDOMEN: _____

BREAST: _____

SKIN: _____

PELVIS: _____

RECTAL: _____

EXTREMITIES: _____

NEURO: _____

PSYCH: _____

VII. REVIEW OF SYSTEMS (PERTINENT POSITIVES) _____

VIII. ASSESSMENT: _____

IX. Plan _____

Date _____ Time _____ Physician Signature _____ Physician Printed Name _____

Lawnwood Regional Medical Center
SURGERY H&P

▼ Patient Information Label ▼

