

Physician History and Physical

Surgery

- GNCH LCH MCH
 SCH RAH UAH OTHER

History

Chief Complaint/ Proposed Surgery Past Illness and Operations Cardiac <input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> MI <input type="checkbox"/> Angina <input type="checkbox"/> CHF <input type="checkbox"/> Cardiac Arrhythmias Respiratory <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> COPD Endocrine <input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Diet Controlled <input type="checkbox"/> Oral Hypoglycemics <input type="checkbox"/> Insulin Controlled <input type="checkbox"/> Thyroid GI/ GU <input type="checkbox"/> None <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> Renal Failure <input type="checkbox"/> Malabsorption Disorder <input type="checkbox"/> GERD Medications <input type="checkbox"/> None Allergies <input type="checkbox"/> None	Ht _____ Wt _____ BP _____ P _____ Pertinent Physical Examination Neck and Head <input type="checkbox"/> No Significant Abnormalities Heart <input type="checkbox"/> No Significant Abnormalities Lungs <input type="checkbox"/> No Significant Abnormalities Abdomen <input type="checkbox"/> No Significant Abnormalities Musculoskeletal <input type="checkbox"/> No Significant Abnormalities Pelvic/ GU <input type="checkbox"/> No Significant Abnormalities L.M. P. General Condition and Diagnosis
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Date Completed _____ Physician (*Print name*) _____

By Family Physician Surgeon Physician (*Signature*) _____

Date Reviewed by Surgeon _____

