



History & Physical

Patient Name: _____ DOB: ____/____/____ Date of Treatment: ____/____/____

Physician: _____ Physician's Phone: () _____

History: (-) if negative, (+) if positive (if positive, please explain below)

- | | |
|--|--|
| ☐ Allergies _____ | ☐ Previous Surgery _____ |
| ☐ Asthma _____ | ☐ Previous Surgical Complications _____ |
| ☐ Diabetes _____ | ☐ Pulmonary Disease _____ |
| ☐ Family History of Bleeding, Muscle Disease,
or Anesthesia Complications _____ | ☐ Recent Exposure to Varicella _____ |
| ☐ Heart Disease _____ | ☐ Sickle Cell Anemia or Variant _____ |
| ☐ Heart Murmur _____ | ☐ Other Conditions or Hematologic Abnormalities
_____ |

Immunizations Up to Date? ☐ Yes ☐ No Recent ASA? ☐ Yes ☐ No _____

Current Medications? ☐ Yes ☐ No _____

List dose(s) and schedule: _____

Physical Examination:

BP: ____/____ Pulse: _____ Resp. Rate: _____ Temp: _____ Height: _____ Weight: _____

(-) if negative/normal, (+) if abnormal (if abnormal, please explain below)

- | | | |
|---------------------------------------|---|--|
| ☐ Abdomen _____ | ☐ Extremities _____ | ☐ Neck _____ |
| ☐ Back _____ | ☐ Eyes _____ | ☐ Neurological _____ |
| ☐ Chest _____ | ☐ Heart _____ | ☐ Nose _____ |
| ☐ Dentition _____ | ☐ Lungs _____ | ☐ Throat _____ |
| ☐ Ears _____ | ☐ Mental Status _____ | ☐ Skin _____ |

Additional Notes: _____

Summary of Findings: _____

Comments/Recommendations Before Surgery: _____

Physician Name (please print): _____

Signature: _____ Date: _____