WILLS EYE
SURGERY CENTER
CENTER CITY

HISTORY AND PHYSICAL EVALUATION FORM

Please fax completed form to _____
(Name & Fax Number of Surgical Coordinator)

This section to be completed by surgeon

Patient Name _____

Pre-Op Diagnosis _____ Proposed Surgery _____

Indications for Surgery: _____

This section to be completed by examining physician or surgeon Latex Allergy: ☐Yes ☐No Smoker: ☐Yes ☐No ETOH: ☐Yes ☐No

Allergies _____

Medications and Supplements _____

_____

PAST MEDICAL HISTORY (Including active medical issues)

_____

_____

_____

PAST SURGICAL HX (Including any anesthetic related issues)

_____

_____

_____

PHYSICAL EXAMINATION

HT: _____ WGT: _____ BMI: _____ AGE: _____

B/P: _____ P: _____ SaO_2 : _____ on room air

GENERAL APPEARANCE: _____

IF NO SIGNIFICANT FINDINGS, CHECK BOX *(Describe abnormal findings)*

- ☐ HEENT _____
- ☐ LUNGS _____
- ☐ HEART _____
- ☐ GI/AB _____
- ☐ GU _____
- ☐ BACK _____
- ☐ EXT _____
- ☐ NEURO _____

Please check applicable boxes:

☐ **A normal healthy patient** <No organic, physiologic, or psychiatric disturbance; excludes the very young and very old; healthy with good exercise tolerance>

☐ **A patient with mild systemic disease** <No functional limitations; has a well-controlled disease of more than one body system or one major system; no immediate danger of death; controlled congestive heart failure (CHF), stable angina, old heart attack, poorly controlled hypertension, morbid obesity, chronic renal failure; bronchospastic disease with intermittent symptoms>

☐ **A patient with severe system disease** <Some functional limitation; has a controlled disease of more than one body system or one major system; no immediate danger of death' controlled congestive heart failure (CHF), stable angina, old heart attack, poorly controlled hypertension, morbid obesity, chronic renal failure; bronchospastic disease with intermittent symptoms>

☐ If patient has pacemaker &/or defibrillator, a recent interrogation of the unit within the past **6 months** is required including response to magnet. Please attach report.

☐ If patient is on Hemodialysis, recent post dialysis labs (including serum potassium & Hb) within the past **2 weeks** is required. Please attach report.

☐ If patient has cardiac stenting, please describe type of stent and comment on plan for *peri-operative* anti-platelet therapy.

☐ If patient has significant CARDIAC history, please attach most recent relevant cardiac studies (stress test, ECG, echocardiogram, cardiac cath, etc).

FOR PEDIATRIC PATIENTS (6 months to 18 years) *Check appropriate box.*

☐ *I have contacted the primary care provider for this patient, Dr. _____, who agrees that it is appropriate to do the surgery in ambulatory surgery center versus a hospital.*

☐ *As the primary care provider for this patient, I agree that it is appropriate for this procedure to be done in a surgery center versus a hospital.*

IMPRESSION *(Please sign below)*

After examining the patient and reviewing the preoperative data, I find this patient to be medically stable for the proposed surgery at a surgery center.

Signature _____ Date _____

Printed Name _____ Phone _____

DAY OF SUGERY PRE OP REVIEW BY ATTENDING

I have reviewed this History and Physical and assessed the patient for changes since its performance. Based upon my assessment no changes have occurred and the patient may proceed with the planned procedure.

Signature _____ Date _____

PATIENT LABEL