McLaren
MACOMB

HISTORY AND PHYSICAL

Name: _____

DOB: _____

Referring Physician: _____

CHIEF COMPLAINT: _____ DATE OF SURGERY: _____

OUTPATIENT SURGERY

HISTORY

HISTORY & INDICATIONS FOR PROCEDURES:

PAST MEDICAL HISTORY: (CHECK ✓ IF PRESENT & APPLICABLE)

☐ No Significant Findings

☐ Hypertension	☐ COPD	☐ Transient Ischemic Attack
☐ Coronary Artery Disease	☐ Asthma	☐ Diabetes Mellitus
☐ Myocardial Infarction	☐ Tuberculosis	☐ Non-Insulin Dependent
☐ Irregular Heart Beat	☐ Reflux	☐ Insulin Dependent
☐ Congestive Heart Failure	☐ Hepatitis	☐ Thyroid
☐ Peripheral Vascular Disease	☐ Ulcers	☐ Cancer
☐ Murmur	☐ Seizures	☐ Renal Failure
☐ Pacemaker/AICD	☐ CVA	☐ Other: _____

☐ OB/GYN Gravida ____ Para _____ Other _____

CURRENT MEDICATIONS & DOSAGES: ☐ NO MEDICATIONS TAKEN

☐ SEE PATIENT PROFILE (Must be attached to this form)

ALLERGIES OR MEDICATION REACTIONS: ☐ NONE KNOWN

☐ LATEX

PEDIATRICS: (IF APPLICABLE)

☐ IMMUNIZATIONS UP TO DATE ☐ IMMUNIZATION STATUS UNKNOWN

PAST SURGICAL HISTORY: ☐ NONE

DIAGNOSIS:

PLANNED PROCEDURE:

PHYSICAL EXAM

VITAL SIGNS:

PULSE: _____ BP: _____ RR: _____ TEMP: _____

HEIGHT: _____ IN/CM WEIGHT: _____ KG/POUNDS

		(SIGNIFICANT FINDINGS)
CARDIOVASCULAR	☐ WNL	
REPIRATORY	☐ WNL	
FAMILY HISTORY:		

SOCIAL HISTORY:

☐ Occupation _____

☐ Tobacco _____

☐ Alcohol _____

☐ Drugs: _____

☐ Abuse: _____

DATE: _____ **TIME:** _____ **PHYSICIAN SIGNATURE:** _____

HISTORY & PHYSICAL UPDATE **(REQUIRED IF H&P IS > 24 HRS BUT < 30 DAYS OLD — Completed Day of Procedure):**

☐ H&P reviewed, patient examined and NO change has occurred in the patient's condition since previous H&P was completed within the last 30 days

☐ A change HAS occurred in the patient's condition since previous H&P was completed within the last 30 days, noted below:

_____

TIME: _____ DATE: _____ PHYSICIAN SIGNATURE: _____

226524

McLaren
MACOMB

HISTORY AND PHYSICAL

SAME DAY SURGERY (FILL OUT IN ADDITION TO OUTPATIENT SURGERY)

REVIEW OF SYSTEMS

☐ Constitutional	☐ Allergy/Immunology	☐ Hematology	☐ Gastrointestinal	☐ Genitourinary
☐ Eyes	☐ Endocrine	☐ Cardiovascular	☐ Integumentary	☐ Psychiatric
☐ ENT	☐ Respiratory	☐ Musculoskeletal	☐ Neurologic	

DIAGNOSTIC FINDINGS: ☐ NONE

PREFERRED ANESTHESIA: ☐ NONE

☐ GENERAL ☐ SPINAL ☐ REGIONAL ☐ ATTENDED LOCAL ☐ EPIDURAL/PAIN BLOCK

☐ LOCAL (NO ANESTHESIA INVOLVEMENT) COMMENT _____

POSITIONING:

☐ SUPINE ☐ LITHOTOMY ☐ SITTING ☐ PRONE ☐ JACKKNIFE ☐ LATERAL

☐ OTHER _____ ☐ POSITIONING AIDES _____

OTHER: ☐ WNL

Physician's Orders/Instructions:

_____

_____

_____

_____

_____

_____

_____

TIME: _____ **DATE:** _____ **PHYSICIAN SIGNATURE:** _____