Mt. Diablo Surgery Center

HISTORY AND PHYSICAL PRE-OP ORDERS

NAME				EXAM DATE		SURGERY DATE
AGE	HT	WT	TEMP	BP	PULSE	RESP.
CHIEF COMPLAINT/PRESENT ILLNESS						

PAST HISTORY:	NEGATIVE	POSITIVE	IF POSITIVE, PLEASE SPECIFY:
OPERATIONS	☐	☐	________________
TRANSFUSIONS	☐	☐	________________
INJURIES	☐	☐	________________
ILLNESS	☐	☐	________________
ALLERGIES	☐	☐	________________
FAMILY HISTORY/ILLNESS	☐	☐	________________
SMOKER/ALCOHOL USE	☐	☐	________________
MEDICATIONS	☐	☐	________________
LMP	DATE: ________________		________________

REVIEW OF SYSTEMS:	NEGATIVE	POSITIVE	IF POSITIVE, PLEASE SPECIFY:
CARDIOVASCULAR	☐	☐	________________
RESPIRATORY	☐	☐	________________
CENTRAL NERVOUS	☐	☐	________________
GENITOURINARY	☐	☐	________________

PHYSICAL EXAM:	NEGATIVE	POSITIVE	IF POSITIVE, PLEASE SPECIFY:
HEENT	☐	☐	________________
BREAST	☐	☐	________________
PULMONARY	☐	☐	________________
CARDIOVASCULAR	☐	☐	________________
ABDOMINAL	☐	☐	________________
MUSCULOSKELETAL	☐	☐	________________
NEUROLOGIC	☐	☐	________________
PELVIC/GU/RECTAL	☐	☐	________________

☐ DEFERRED – Patient advised to have primary care M.D. exam

INDICATIONS FOR SURGERY:

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OPERATIVE CONSENT TO READ:

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PRE-OP ORDERS (IF INDICATED)

LAB PREADMISSION

☐ CBC ☐ K ☐ UA ☐ OTHER

☐ EKG, If patient is ≥ 50 y.o. or has history of hypertension or cardiovascular disease. If patient has had EKG within the past year obtain copy from primary care M.D.

☐ IV ________________ Solution _________Rate/Hour

☐ ________________________________

☐ ________________________________

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Physician Signature **Date** **Time**

I have fully explained the potential benefits, risks, and complications of the proposed surgical procedure to the patient, as well as the alternative treatments. All questions have been answered. The patient wishes to proceed.

PLEASE FAX TO (925) 674-1154