Same Day Surgical Admission H & P

Patient _____ **DOB** _____ **Sex** _____

Ht: _____ **Wt:** _____ **HR:** _____ **R:** _____ **BP:** _____ **Temp:** _____

Diagnosis _____
_____
_____

Proposed Surgery _____
_____
_____

Past Medical History _____
_____
_____

Previous Surgeries _____
_____
_____

Anesthesia History (Please indicate any difficulty with prior anesthesia or family difficulties with anesthesia) _____
_____
_____

Allergies/Reactions _____
_____
_____

Current Medications (name, dose, schedule, indication) _____
_____
_____

Immunizations: Up to date if not, explain _____
_____

Physical Examination

		WNL
General		
Skin		
Head		
Eyes		
ENT		
Back and Throat		
Heart		
Lungs		
Abdomen		
Genitalia		
Extremities		
Neuro		
Comments		

On the basis of the examination, I approve this patient's schedule same day surgical procedure

_____ Date: _____
Physician's Signature

Physician's printed name _____
Address _____
_____

Patient's Name _____ **DOB** _____ **Sex** _____

Please fax this form to **847-297-8760**