PATIENT NAME (LAST) (FIRST)

[All surgical patients, including those who are scheduled for local, topical, or no anesthesia, must have the areas marked with an **asterisk (*)** completed in accordance with HCFA regulations.]

* ADMITTING DIAGNOSIS	* PROPOSED OPERATION

*** CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS**

*** SIGNIFICANT PAST MEDICAL & FAMILY HISTORY**
(Including presence or absence of bleeding problems, previous hospitalizations, surgery, habits)

* CURRENT MEDICATIONS	* ALLERGIES/DRUG SENSITIVITIES

PHYSICAL EXAMINATION

**** NOTE:** For patients scheduled for surgical procedures under local, regional, topical, or no anesthesia, the examination must be specific to the proposed procedure and any existing comorbid conditions.

HEIGHT	WEIGHT	TEMP.	PULSE	RESP.	B.P.

SKIN	
HEAD	
ENT	
EYE	
HEART	
LUNGS	
ABDOMEN	
GENITALIA	
BREASTS	
PELVIC/ PAP SMEAR	
RECTAL	
EXTREMITIES	
NEURO-EXAM	

PRE-OPERATIVE MEDICATIONS REQUIRED	PHYSICIAN'S SIGNATURE	DATE/TIME

Patient Label

SURGICAL HISTORY & PHYSICAL