HISTORY & PHYSICAL

TAKE THIS TO YOUR DOCTOR

AFTER: _____ NAME:
BEFORE: _____ DOB:

****PLEASE NOTE YOU MUST HAVE YOUR PHYSICAL DONE BETWEEN THESE DATES OR IT WILL NOT BE VALID FOR YOUR SURGERY****

Chief Complaint: **Decreased vision due to cataract**

Planned Procedure: **Phaco with Interocular lens** Planned Procedure Date:

Surgeon: **Dr. Juli A. Larson** Problem List Available or Initiated: ( ) Yes ( ) No

History of Present Illness: (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Signs & Symptoms)

Past Medical/Surgical History: (Hospitalizations, Anesthetic Complications, Immunizations)

Family History:

Social History:

Current Medications:

Allergies/ Sensitivities: ( ) No ( ) Yes, Please explain.

REVIEW OF SYSTEMS:	Negative	Positive	Details
Constitutional	_____	_____	
Cardiovascular	_____	_____	
Respiratory	_____	_____	
Gastrointestinal	_____	_____	
Genitourinary	_____	_____	
OB/GYN	_____	_____	
Musculoskeletal	_____	_____	
Neurological	_____	_____	
Psychiatric	_____	_____	
Hematologic/Lymphatic	_____	_____	
Endocrine	_____	_____	
Eyes	_____	_____	
Ears, Nose, Mouth, Throat	_____	_____	
Integumentary	_____	_____	
Allergies/Immunologic	_____	_____	

Patient Name:_____

( ) Communicable Disease: Exposure / Risk (Hepatitis, Chicken Pox, Measles, TB) ( )VRE ( ) MRSA

PHYSICAL EXAM: (Complete each item. Explain Abnormal.)

Height: _____ Weight: _____(kg) Vital Signs: BP:_____ P: _____ T: _____

Constitution / General

EENT & Mouth

Skin, Nodes, Glands

Respiratory

Heart

Peripheral Vascular

Breasts / Axillae

Abdomen

Scrotum / Testes

Pelvic

Rectal

Musculoskeletal

Neurologic

IMPRESSION: _____
PLAN: Labs: _____ EKG: _____ CXR: _____ Antibiotic Ordered:_____Consults:_____
Blood Available: _____ Pain Management:_____

** PLEASE INCLUDE EKG, IF NOT DONE WITHIN THE PAST 6 MONTHS.

Date: _____ Time:_____ Examiner Signature:_____
If MD is billing provider, Nurse Practitioner/Physician Assistant must attest:
I was directly supervised by_____ who was present in the office suite and was immediately available.
Date: _____ Time:_____ Signature:_____
ATTENDING ASSESSMENT: Evaluation Service performed by a resident followed by a teaching physician: Teaching physician must personally document and sigh, "Patient seen and examined. I concur with (or have revised) the resident's history, examination, and medical decision making." Very briefly summarize history. Upon examination, document teaching physician's key findings.

Date:_____ Time:_____ Attending Signature:_____

Copy sent to:_____ (requesting provider) on: Date:_____

Note: if there is a change in the patient's clinical condition or it is greater than 7 days and less than 30 since history & physical, an interval note is required.
( ) Condition changed. See interval note. ( ) Patient's condition unchanged since H&P originally performed.

Date:_____ Time:_____ Provider Name (Print) _____ Signature:_____

Please fax results (on this form OR your own)
to our office when completed.