HISTORY AND PHYSICAL EXAM

Patient: ______________________________ is scheduled for ______________________________surgery.
(Adults generally under local/standby anesthesia)

Surgeon: **Robert E. Feinfield, M.D.** **Mireille P. Hamparian, M.D.** **Alan M. Berg, M.D.** **Barbara S. Yates, M.D.**

PCP:______________________

Date: __________ **at**__________

On: __________ **at** ***PACIFIC SURGERY CENTER***
(DATE) **2829 W. BURBANK BLVD., Burbank, CA 91505**
PH (818) 567-0348 OR FAX (818) 567-2859

PLEASE MAIL OR FAX THIS REPORT TO ARRIVE AT PACIFIC SURGERY CENTER AT LEAST 1 DAY PRIOR TO SURGERY.

We need to know if this patient is approved for outpatient surgery under local/standby anesthesia.

TAKE TO YOUR PRIMARY CARE DOCTOR 7-10 DAYS BEFORE SURGERY

PLEASE NOTE:

1. **PSC REQUIRES AN EKG FOR ALL PATIENTS OVER 40.**
2. **ALL SURGERIES REQUIRE A CBC.**
3. **EYELID SURGERIES NEED PT, PTT & CBC WITHIN 48 HOURS OF SURGERY.**
4. **PRIMARY CARE PHYSICIAN MAY REQUIRE OTHER TESTS OR LABS TO CLEAR FOR SURGERY.**

CHIEF COMPLAINT: ______________________________
DIAGNOSIS: ______________________________

PAST MEDICAL HISTORY: (IF YES, PLEASE EXPLAIN)

____	HIGH BLOOD PRESSURE ____	____	ARTHRITIS ____
____	HEART DISEASE ____	____	BACK PAIN ____
____	HEART ATTACK ____	____	FAINTING ____
____	STROKE ____	____	THYROID DISEASE ____
____	ASTHMA ____	____	TUBERCULOSIS ____
____	COPD ____	____	PRIOR ANESTHESIA ____
____	RENAL DISEASE ____	____	DENTURES ____
____	DIABETES ____	____	SMOKE ____
____	BLEEDING DISORDER ____	____	ALCOHOL ____
____	BLOOD TRANSFUSION ____	____	HEPATITIS OR JAUNDICE ____
____	CANCER ____	____	G.I. PROBLEMS ____

MEDICAL ALLERGIES: ____________________ REACTIONS: ____________________
HOSPITALIZATIONS & SURGICAL HISTORY: ______________________________
____
MEDICATIONS: ______________________________
____
COMMENTS: ______________________________
____

PHYSICAL EXAM: WT: ______HT: ______ B/P: ______ PULSE: ______ TEMP: ______

NORMAL

HEART/EKG:______________________________
LUNGS:______________________________
EENT: ______________________________
ABDOMEN: ______________________________
CHEST:______________________________
EXTREMITIES:______________________________
MENTAL STATUS: ______________________________
OTHER: ______________________________

PHYSICAL EXAM FINDINGS: THIS PATIENT'S HEALTH IS SATISFACTORY AND THE PATIENT IS CLEARED FOR SURGERY IN AN AMBULATORY SETTING.

______________________________**M.D.**
PHYSICIAN NAME (PLEASE PRINT)

______________________________**M.D.**
PHYSICIAN SIGNATURE

PHONE NUMBER: (____)__________-__________

DATE ____________________