



AMBULATORY SURGERY HISTORY AND PHYSICAL EXAMINATION

Date: _____ Time: _____

Name: _____ Age: _____

Chief Complaint: _____

Present Illness: _____

Past Medical History: _____

Previous Operations: _____

Family History: _____

Social History: _____

Medications: _____

Allergies: _____

Family Physician: _____

PHYSICAL EXAMINATION:

Vital Signs: BP: _____, TEMP: _____, P: _____, RR: _____, Ht: _____, Wt: _____

HEENT: _____

Neck: _____

Chest: _____

Heart: _____

Breasts: _____

Abdomen: _____

Genital / Rectal: _____

Extremities / Skin: _____

Neurological: _____

Impression: _____

Signature _____ ID # _____ Date _____ Time _____



AMBULATORY SURGERY ORDER SHEET

NAME: _____	SURGEON: _____
AGE: _____	OPERATION: _____
TELEPHONE: _____	TIME NEEDED: _____
PRE-ADMISSION TESTING: _____	TYPE ANESTHESIA: _____
DATE: _____	SURGERY DATE: _____
TIME: _____	

SPECIAL NEEDS: (instruments, cultures, frozen sections, interpreter)

PROCEDURES ORDERED:

<u>CBC required</u> <u>Urine required</u> <u>Bloom Chem (Specify)</u> <u>EKG</u> <input type="checkbox"/> Yes <input type="checkbox"/> No (required over age 40)	<u>Chest X-ray</u> <input type="checkbox"/> Yes <input type="checkbox"/> No (REQUIRED COVERAGE 60) <u>Other X-ray</u> <u>X-ray Films needed in OR</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <u>X-ray to be taken in OR</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
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OTHER:

Signature: _____

Date: _____

PREOPERATIVE INSTRUCTION SHEET GIVEN TO PATIENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OLD CHART ORDERED FROM MEDICAL RECORDS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PATIENT DIRECTED TO BUSINESS OFFICE	<input type="checkbox"/> YES	<input type="checkbox"/> NO