A S 2 C 0 0 8

Stony Brook Medicine
Stony Brook, NY 11794

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

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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:

CBC required
Urine required
Bloom Chem (Specify)
EKG ☐ Yes ☐ No
(required over age 40)

Chest X-ray ☐ Yes ☐ No (REQUIRED COVERAGE 60)
Other X-ray
X-ray Films needed in OR ☐ Yes ☐ No
X-ray to be taken in OR ☐ Yes ☐ No

OTHER:

Signature: Date:

PREOPERATIVE INSTRUCTION SHEET GIVEN TO PATIENT	☐ YES	☐ NO
OLD CHART ORDERED FROM MEDICAL RECORDS	☐ YES	☐ NO
PATIENT DIRECTED TO BUSINESS OFFICE	☐ YES	☐ NO