Surgical Arts Center
711 W. Lancaster Ave, Suite 300
Bryn Mawr, PA 19010
Phone: (484)222-6844
Fax: (484)222-6831

History and Physical Evaluation Form

Patient Name: _____ Physician: _____

Date of Birth: _____ /_____ /_____ Age: _____ Date of Surgery: _____ /_____ / _____

CHIEF COMPLAINT: _____

HPI: _____

This form must be completed and dated within 30 days of the date of surgery. Please complete this form and return it to the patient for forwarding to the Center or mail/fax the completed form to the address provided above. Thank you for participating in this patient's care.

Past Medical History: ❒ None

_____

_____

_____

Current Medications (dosage, frequency. and route): ❒ None

_____

_____

_____

Past Surgical History (with dates): ❒ None

_____

_____

_____

Allergies/Reactions: ❒ None known or acknowledged

_____

_____

_____

Social History: SMOKE: ❒No ❒ Yes(___ppd) ALCOHOL: ❒ No ❒Yes Amount/Freq: _____ OTHER: _____

Family History: ❒Negative ❒ Positive : _____

Review of Systems: ❒ Negative ❒ Positive: _____

PHYSICAL EXAMINATION: Height: _____ Weight: _____

Evaluation of body functions related to patient's specific complaint: _____

	No Significant Findings	Describe Abnormal Findings
❒ Heart		_____
❒ Lungs		_____

Blood Pressure: _____ / _____

Pre-operative Studies (labs, EKG, etc): ❒Required studies included with this form ❒ Required studies faxed to facility (date: ___/___ /____)

Comments: _____

Physician Signature: _____ ❒ MD ❒ DO DATE: _____/_____/_____

Print Name: _____

Pediatric Clearance (Children under 18 years of age)

❒ I am the patient's primary care pediatric provider. This pediatric patient is medically cleared and is capable of proceeding with the proposed procedure(s) and I agree that Surgical Arts Center is an appropriate site of care.

❒ Dr. _____ (patient's PCP) was contacted at Phone #: _____ and agreed that Surgical Arts Center was an acceptable facility for the procedure.

❒ Surgeon was unable to contact the patient's Primary Care Physician regarding the appropriateness of this location for the patient's surgical procedure.

Reason: _____

H & P - DAY OF SURGERY - Update Assessment Note:

The patient remains with the appropriate indications for the planned operative procedure and there has been no change in their medical status/condition, unless as noted: ❒ Other: _____

Physician Signature: _____ Date: _____ / _____ / _____