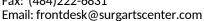
Surgical Arts Center

711 W. Lancaster Ave, STE 300, Bryn

Mawr, PA 19010 Phone: (484)222-6844 Fax: (484)222-6831







History and Physical Evaluation Form

This form must be completed and dated <u>within 30 days of the date of surgery</u>. Please complete this form and return it to the patient so they may return it to us. You may also mail, fax, or email it to the address provided above. Thank you for participating in this patient's care.

Patient Name:	Surgeon: Date of Surgery:/		
Date of Birth:/ Age:	Type of Anesthesia:		
CHIEF COMPLAINT:			
HPI: Past Medical History: None	Current Medications (dosage, frequency, and route):		
Past Surgical History (with dates): □ None	Allergies/Reactions:		
Social History: SMOKE: □No □ Yes(ppd) ALCOHO Family History: □Negative □ Positive: Review of Systems: □ Negative □ Positive PHYSICAL EXAMINATION: Height: Weight: Evaluation of body functions related to patient's specific cor	BMI: Blood Pressure:/		
o Significant Findings			
□ Heart	Lungs		
Pre-Operative Studies (labs, EKG, etc): □Required studies/	s included w/ this form Required studies faxed to facility (Date:/)		
Is this patient cleared for surgery? ☐ YES ☐ NO	; Reason:		
Physician Signature:			
Print Name:			
☐ I am the patient's primary care pediatric provider. This pediatric procedure(s) and I agree that Surgical Arts Center is an appropride Dr (patient's PCP) was contacted a was an acceptable facility for the procedure.	at Phone #: and agreed that Surgical Arts Center ysician regarding the appropriateness of this location for the patient's surgical procedure.		

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: ______

Surgeon Signature:	Date://	Time:	AM / PM