

Surgical Arts Center

711 W. Lancaster Ave, STE 300, Bryn

Mawr, PA 19010

Phone: (484)222-6844

Fax: (484)222-6831

Email: frontdesk@surgartscenter.com

**SURGICAL
ARTS
CENTER****History and Physical Evaluation Form**

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 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: _____ ICD: _____

HPI: _____

Past Medical History: ☐ NoneCurrent Medications (dosage, frequency, and route): ☐ None_____

_____Past Surgical History (with dates): ☐ NoneAllergies/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: _____ BMI: _____ Blood Pressure: ____/____

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

No Significant Findings Describe Abnormal FindingsNo Significant Findings Describe Abnormal Findings☐ Heart _____☐ Lungs _____Pre-Operative Studies (labs, EKG, etc): ☐ Required studies included w/ this form ☐ Required studies faxed to facility (Date: ____/____/____)**Is this patient cleared for surgery?** ☐ YES ☐ NO; Reason: _____Physician Signature: _____ ☐ MD ☐ DO DATE: ____/____/____

Print Name: _____

Pediatric Clearance (Children < 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: _____

Surgeon Signature: _____ **Date:** ____/____/____ **Time:** _____ AM / PM