Surgical Arts Center
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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: ☐ 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: _____ BMI: _____ Blood Pressure: _____/_____

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

No Significant Findings	Describe Abnormal Findings	No 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: _____

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 an Outpatient Ambulatory Surgery Center is an appropriate site of care. (Surgical Arts Center)
☐ Dr. (patient's PCP) was contacted at Phone #: _____. and agreed that an Outpatient Ambulatory Surgery Center (Surgical Arts Center) is an acceptable facility for the procedure. Contacting Surgeon Signature: _____
☐ Surgeon was unable to contact the patient's Primary Care Physician regarding the appropriateness of this location for the patient's surgical procedure.

Reason:_____

Physician Signature: _____ ☐ **MD** ☐ **DO** **DATE:** ____/____/____

Print Name: _____

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