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: ☐ 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: ___/ ___/__)

Do you have any special considerations (medical, religious, cultural, or personal)? _____

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**