HISTORY AND PHYSICAL

_____
Patient Name

IMPRESSION: PREOPERATIVE DIAGNOSIS: _____
_____

INDICATION FOR PROCEDURE: _____
_____
_____

PLAN: _____
_____
_____

HT: _____ **WT:** _____ **T:** _____ **BP:** _____ **P:** _____ **R:** _____

DRUG ALLERGIES: _____
_____

CURRENT MEDICATIONS: _____
_____

MEDICAL HISTORY: _____
_____

SURGICAL HISTORY: _____
_____

RELEVANT FAMILY HISTORY: _____
_____
_____

PHYSICAL EXAMINATION:

	NORMAL	ABNORMAL	DESCRIBE
HEENT			
CARDIOVASCULAR			
PULMONARY			
GI			
GU			
MUSCULOSKELETAL			
NEUROLOGIC			
OTHER			

PHYSICIAN SIGNATURE **DATE**

Skolnick Eye Institute (561) 296-2010 Fax (561) 296-2001

NAME:
MRN:
AGE: **DOB:**
DOS: