GENERAL HISTORY & PHYSICAL EXAMINATION
AMBULATORY SURGERY

Please fax this completed form to

Park Avenue Medical Suite, PLLC
Fax: 212-504-9511 | Phone: 212-792-6378
Email: info.pams.pllc@gmail.com

PATIENT NAME:

DATE OF SURGERY:

PROCEDURE:

GENERAL MEDICAL HISTORY

AGE ________ **M F Ht.** _________ **Wt.** _________

CHIEF COMPLAINT: ________________________

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PRESENT ILLNESS: ________________________

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PAST HISTORY ***(surgery, major illness, hosp., etc.):***

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FAMILY HISTORY: ________________________

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ALLERGIES: ________________________

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ANESTHESIA PROBLEMS: ________________________

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MEDICATIONS/SUPPLEMENTS & DOSAGE:

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GENERAL PHYSICAL EXAMINATION

B/P: _____ **PULSE:** _____ **RESP:** _____ **TEMP:** _____

NECK: ________________________

CHEST: ________________________

BREASTS: ________________________

HEART: ________________________

ABDOMEN: ________________________

BLEEDING TENDENCIES: YES NO

____

EXTREMITIES: ________________________

SKIN: ________________________

NEUROLOGICAL: ________________________

LYMPH: ________________________

RECTAL: ________________________

IMPRESSION: ________________________

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MD SIGNATURE: ________________________

NAME: ________________________

LICENSE # ________________ **DATE:** _________

PHONE: ________________________

ADDRESS: ________________________

DAY OF SURGERY UPDATE

□ **Patient evaluated, no changes in H&P**

□ **H&P has changed (see reverse side for comments)**

MD SIGNATURE: ________________________

DATE: ________________________