TRI·COUNTY SURGERY CENTER

History & Physical Evaluation

patient label to be attached by Center

Patient Name: _____ Date of Birth: _____

Date of Proposed Surgery: _____ Sex: Male Female Age: _____ TCSC MR#_____

Pre-Op Diagnosis: _____

Proposed Procedure(s):_____

This form must be dated **within 30 days of the date of procedure and faxed to 215-396-4201 no later than 5 days before the date of procedure**. Thank you for your ongoing participation in the care of our mutual patient.

Allergies: _____

Habits: Smoker: _____ ETOH: _____ Other: _____

Current Medications: _____

_____

PAST MEDICAL HISTORY (include pulmonary, cardiac, psych) _____

_____

PAST SURGICAL HISTORY _____

_____

PHYSICAL EXAM HT: _____ WT: _____ BP:_____ P:_____ R:_____

General Appearance: _____

Check Box If Normal — Describe Abnormal Findings

HEENT _____

Lungs _____

Heart _____

GI/AB _____

GU _____

Back _____

Extremities _____

Neuro _____

EKG & LAB DATA: (TCSC does NOT require any specific lab or EKG data unless specifically requested by anesthesia. The PCP may order any labs/EKG they feel is needed to appropriately clear pt for surgery)

IMPRESSION: I find this patient to be medically cleared for the proposed procedure(s).

Print/Stamp Name: _____

Signature: _____ Date:_____ Phone:_____

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www.tricountysurgerycenter.com