HISTORY AND PHYSICAL

MUST BE TYPEWRITTEN and
30 days or less of Procedure

Procedure Date:

Last Name:	**First Name:**	**MI:**
MRN/History #:	Date of Birth:	☐ Male ☐ Female
Patient Cell Phone:	Patient Home Phone:	
Patient Work Phone:	☐ Preauthorization Complete ☐ Pending ☐ Not Required	
Primary Insurance:	Preauthorization #:	

Reason for Procedure:		
History of Present Illness:		
Past Medical History:		
Current Medications:	Dose:	Frequency:
Medication Allergies: Reaction:		
Past Surgical History: Anesthesia Problems/Concerns:		
Social History: ☐ Smoker # packs/day: yrs.: ☐ ETOH # per Last drink: ☐ Recreational Drug Use How Often:		
Review of Systems: (General State of Health and Function)		

Physical Exam:

Weight: kg	Height: cm in	and/or BMI:
BP:	Pulse:	Respirations:

Exam Review:

Cardiac:

Pulmonary:

Laboratory and Diagnostic Imaging Results:

Assessment:

Plan for Procedure:

Physician Signature: Date:

Print and Fax to (509) 665-6208 when completed.