



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:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Cell Phone:	Patient Home Phone:	
Patient Work Phone:	<input type="checkbox"/> Preauthorization Complete <input type="checkbox"/> Pending <input type="checkbox"/> 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:		
<input type="checkbox"/> Smoker # packs/day: yrs.:		
<input type="checkbox"/> ETOH # per Last drink:		
<input type="checkbox"/> 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.