

Women's Physician Surgery Center  
8081 Township Line Rd  
Indianapolis, IN 46260  
(317) 228-1100

## PRE-OPERATIVE HISTORY AND PHYSICAL FORM

(PATIENT IDENTIFICATION)

### TO BE COMPLETED BY PATIENT, NURSE OR PHYSICIAN

#### I. HISTORY (PLACE ADDITIONAL COMMENTS ON BACK)

##### PATIENT INFORMATION

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX  M  F

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

ANY MEDICATION REACTION:  YES  NO \_\_\_\_\_

CURRENT MEDICATIONS AND DOSAGE: \_\_\_\_\_

	NEG.	POS.	POS. (EXPLAIN)		NEG.	POS.	POS. (EXPLAIN)
RESPIRATORY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	_____	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
SMOKER	<input type="checkbox"/>	<input type="checkbox"/>	_____	RENAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	NEUROLOGIC DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	_____	INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	_____	STEROID USE IN PAST 2 MO.	<input type="checkbox"/>	<input type="checkbox"/>	_____
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALCOHOL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____	ILLICIT DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	_____
EPILEPSY/SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	_____	POST OP NAUSEA HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____	HISTORY OR FAMILY HISTORY			_____
GASTRO INTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	_____	OF ANESTHESIA PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____

COMMENTS: \_\_\_\_\_

FERTILE FEMALE

STERILIZED

ABOVE HX INFORMATION ENTIRELY NEGATIVE

### TO BE COMPLETED BY PHYSICIAN PERFORMING PROCEDURE

SURGEON'S NAME: \_\_\_\_\_ DATE OF SURGERY: \_\_\_\_\_

REVIEW RISKS AND BENEFITS OF SURGICAL PROCEDURE:  YES  NO \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

INDICATIONS/SYMPTOMS/PRE OP DX SURGICAL PROCEDURES: \_\_\_\_\_

SURGICAL PROCEDURE: \_\_\_\_\_

ANESTHESIA TYPE:  GEN  M.A.C.  REGIONAL-SPINAL, EPIDURAL, BIER BLOCK, AXILLARY, CHOICE

IV SED  LOCAL  ANESTHESIA THERAPEUTIC BLOCK

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II. PHYSICAL	NOT EXAMINED			NEG			ABNORMAL		
	NOT EXAMINED	NEG	ABNORMAL	NOT EXAMINED	NEG	ABNORMAL			
MENTAL STATUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	OTHER _____				
					PELVIC EXAM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

MD Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN ON THE DAY OF THE PROCEDURE**

Reviewed: \_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Date