



AMBULATORY SURGERY HISTORY AND PHYSICAL EXAMINATION

Date: _____ Time: _____

Name: _____ Age: _____

Chief Complaint: _____

Present Illness: _____

Past Medical History: _____

Previous Operations: _____

Family History: _____

Social History: _____

Medications: _____

Allergies: _____

Family Physician: _____

PHYSICAL EXAMINATION:

Vital Signs: BP: _____, TEMP.: _____, P.: _____, RR: _____, Ht: _____, Wt: _____

HEENT: _____

Neck: _____

Chest: _____

Heart: _____

Breasts: _____

Abdomen: _____

Genital / Rectal: _____

Extremities / Skin: _____

Neurological: _____

Impression: _____

Signature _____ ID # _____ Date _____ Time _____



AMBULATORY SURGERY ORDER SHEET

NAME: _____

SURGEON: _____

AGE: _____

OPERATION: _____

TELEPHONE: _____

TIME NEEDED: _____

PRE-ADMISSION TESTING: _____

TYPE ANESTHESIA: _____

DATE: _____

SURGERY DATE: _____

TIME: _____

SPECIAL NEEDS: (instruments, cultures, frozen sections, interpreter)

PROCEDURES ORDERED:

CBC required

Chest X-ray Yes No (REQUIRED COVERAGE 60)

Urine required

Other X-ray

Bloom Chem (Specify)

X-ray Films needed in OR Yes No

EKG Yes No

X-ray to be taken in OR Yes No

(required over age 40)

OTHER:

Signature: _____

Date: _____

PREOPERATIVE INSTRUCTION SHEET GIVEN TO PATIENT

YES NO

OLD CHART ORDERED FROM MEDICAL RECORDS

YES NO

PATIENT DIRECTED TO BUSINESS OFFICE

YES NO