



# History & Physical

Pt. Name: \_\_\_\_\_

DOB: \_\_\_\_\_



Please fax completed form to  
Bright Eye Consultants 865.262.8551  
Children's West Surgery Center 865.670.9082

Chief Complaint: \_\_\_\_\_

Present Illness (include justification for admission): \_\_\_\_\_

PAST MEDICAL HISTORY: \_\_\_\_\_

List drug reaction/allergies: \_\_\_\_\_

List Medications: \_\_\_\_\_

List Previous Surgery: \_\_\_\_\_

None:

R.O.S negative <input type="checkbox"/> except:		Yes	No
Family Hx negative: <input type="checkbox"/> except:	Tobacco		
Social Hx negative: <input type="checkbox"/> except:	Alcohol		
PHYSICAL EXAM: Height	Weight	Temp	Pulse
	R	BP	

	NORMAL	ABNORMAL	N/A	Describe abnormal findings below
HEENT				
CV System				
Lungs				
Abdomen				
Genital/Urinary				
Muscular Skeletal System				
Neurologic				
Psycho-Social				
Skin				

IMPRESSION: \_\_\_\_\_

ASA Risk Category

- Patient is a completely healthy fit patient.
- Patient has mild systemic disease.
- Patient has severe systemic disease that is not incapacitating.
- Patient has incapacitating disease that is a constant threat to life.
- A moribund patient who is not expected to live 24 hour with or without surgery.
- The patient's pre-existing medical conditions are optimized for surgery in an ambulatory setting.**

Physician Signature \_\_\_\_\_ Practice Name \_\_\_\_\_

Physician Name \_\_\_\_\_ Date \_\_\_\_\_