Surgery Center of Fairfield County
Patient History & Physical

Name _____
DOB _____
DOS _____

Chief Complaint/History of Present Illness: _____

Pre-Operative Diagnosis/Indication for Surgery: _____

Proposed Procedure: _____

ASA Classification: I Normal/ Healthy II Mild Systemic disease
(PAIN & GI ONLY) III Severe Systemic Disease IV Severe Systemic Disease that is a constant threat to life
(Non-Surgical procedures)

Complete for all surgeries/procedures:

System Review	Normal	Abnormal/Explain	Current Medications: ☐ None ☐ See Medication List
Heart/CV			
Pulmonary			
HEENT			
Neuro			
Abdomen			
Musculoskeletal			Allergies/Reactions: ☐ NKA
Hepatic / GI			
Renal / GU			
Mental Status			
			Smoking: ☐ No ☐ Yes: Amount:
Constitutional Symptoms (fever, weight loss, etc.):			Alcohol Use: ☐ No ☐ Yes: Amount: Drug Use: ☐ No ☐ Yes: List:
Past major illnesses/injuries: ☐Yes ☐ None If yes, list: _____ _____ _____ Family History: ☐ Negative Other: _____ _____			Medical History: ☐ Diabetes: ☐ Insulin ☐ Oral Meds ☐ Diet Controlled ☐ Hypertension ☐ Hepatitis ☐ Heart Disease ☐ Seizure Disorder ☐ Stroke ☐ Sleep Apnea ☐ Asthma ☐ Cancer ☐ Bleeding Tendency ☐ Other: _____
Previous Surgeries/Hospitalizations:			Current Comorbid Conditions: ☐ None ☐ Yes: describe

I have determined that this patient is medically optimized and is a suitable candidate for the planned procedure at this facility.

Examining Physician's Signature: _____ **Date:** _____ **Time:** _____

Complete This Section on Day of Service for History and Physical Performed within the Past 30 Days

No change in patient condition noted after patient examination & review of H&P and admission patient history. I have determined that this patient is a suitable candidate for the planned procedure at this facility today. I have answered all the patient's/guardian's questions. The patient/guardian accepts the proposed procedural/surgical plan.

Physician Signature: _____ **Date:** _____ **Time:** _____

Complete This Section for any CHANGES in patient condition on Day of Service

Change in patient condition noted after patient examination & review of H&P and admission patient history:
Describe: _____

Physician Signature: _____ **Date:** _____ **Time:** _____

BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

CONSULTATION

TO DR.

PATIENT

REQUESTED BY: _____ M.D.

Addressograph

PRE-PROCEDURE MEDICAL EVALUATION

TO DR.

DATE OF CONSULTATION

PATIENT HISTORY / REVIEW OF SYSTEMS

PRIOR SURGERY / ANESTHESIA

ALLERGIES

MEDICATIONS / DOSAGES

PHYSICAL EXAM

VITAL SIGNS: BP _____ PULSE _____ RESP. _____ TEMP. _____

MENTAL STATUS ☐ ALERT AND ORIENTED ☐ OTHER (SPECIFY):

HEART

LUNG

OTHER PERTINENT FINDINGS

PATIENT IN OPTIMAL MEDICAL CONDITION FOR PLANNED PROCEDURE ☐ YES ☐ NO (EXPLAIN)

RECOMMENDATIONS FOR CONTINUING THERAPY DURING PERIOPERATIVE PERIOD.

_____ M.D.