Fax 313-343-8739

035

DOB

OPERATIVE AND INVASIVE PROCEDURE HISTORY AND PHYSICAL

PATIENT NAME
LAST _____ FIRST _____

PARENT / GUARDIAN NAME HOME PHONE _____ ALT#/PAGER _____

LAST _____ FIRST _____

SURGERY/PROCEDURE DATE _____ SURGEON/PHYSICIAN Dr. Dawn Harvey

DIAGNOSIS _____

PROCEDURE Complete Dental treatment under G.A.

MEDICATIONS _____

ALLERGIES _____

CHIEF COMPLAINT AND HISTORY OF PRESENT PROBLEM(S) _____

PAST BIRTH / MEDICAL / HOSPITALIZATIONS _____

SURGICAL HISTORY _____

REVIEW OF SYSTEMS _____

SOCIAL HISTORY _____

PHYSICAL EXAM (Normal is not an acceptable description)

General _____

HEENT _____

Heart _____

Lungs _____

Abdomen _____

Extremities _____

Other Weight Weight BMI

PATIENT NAME _____
Last First

OPERATIVE AND INVASIVE PROCEDURE HISTORY AND PHYSICAL CONTINUED

COMMENTS / SPECIALTY EXAM

SIGNATURE/TITLE X _____ DATE/TIME X _____

PROCEDURE/OPERATIVE NOTES

PRE DIAGNOSIS _____

POST DIAGNOSIS _____

PROCEDURE _____

FINDINGS _____

COMPLICATIONS _____

FLUIDS/BLOODS ADMINISTERED _____

TUBES/DRAINS, ETC. _____

SURGEON'S/PHYSICIAN'S DISCHARGE/DISPOSITION NOTE

TO: INPT. UNIT/OBSERVATION/HOME/OTHER: _____

Signature/Title _____ (Date/Time)