

(To be used only if planned admission is less than 48 hours)

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS

PAST MEDICAL HISTORY

Past Surgeries

Relevant Family History

Allergies

NKDA Latex Allergy

Medications

Social History Tobacco packs/year

ETOH

Street Drugs

REVIEW OF SYSTEMS

CARDIOVASCULAR

- Hypertension
 Coronary Artery Disease
 Angina
 MI
 CABG
 Stable
 Dysrhythmia
 CHF
 Valvular Dis
 Rheumatic Heart Dis
 Other:
 Peripheral Vascular Disease
 Source of Infection
 Skin
 Indwelling Catheter
 Prosthesis
 Other:

RESPIRATORY

- Asthma
 Last Attack:
 Chronic Bronchitis
 Pneumonia
 COPD
 URI
 Tuberculosis
 Sleep Apnea
 CPAP
 Home O2
 Other:

SKELETAL

- Osteoarthritis
 Rheumatoid Arthritis
 Spinal disc disease
 Trauma
 Other:

GI

- Obesity
 Peptic Ulcer Dis
 Gastro Esophageal Reflux Disease
 Hiatal Hernia
 Jaundice
 Hepatitis A, B, C
 Other:

NEUROLOGIC

- Seizure
 Stroke/TIA
 Neuropathy
 Neuro Musc. Dis
 Other:

GU

- Renal Insufficiency
 Endstage Renal Disease
 Dialysis
 UTI
 Urinary Retention
 BPH
 Other:

ENDOCRINE

- Diabetes Type 1 Type 2
 Thyroid
 Post Menopausal
 Other:

HEMATOLOGIC

- Anemia
 Coagulopathy
 Other:
 Prior Transfusion

PHYSICAL EXAMINATION

Vital Signs: BP TEMP PULSE RESP

Table with 4 columns: System, Normal, Abnormal, and IF ABNORMAL, SPECIFY FINDINGS. Rows include Skin, Head / Ears / Nose / Throat, Heart, Lungs, Abdomen, Extremities, and GU.

PLEASE CONTINUE ON REVERSE SIDE



AMBULATORY SURGERY / SHORT STAY HISTORY AND PHYSICAL

5900 WEST OLYMPIC BLVD. LOS ANGELES, CA 90036-4671

PATIENT ID

PERTINENT / ABNORMAL LAB, XRAY, EKG RESULTS

PLAN OF CARE

Preop Interventions:

SUMMARY OF FINDINGS / FINAL DIAGNOSES

ARE THE PATIENT'S MEDICAL CONDITIONS OPTIMIZED FOR SURGERY? **YES** **NO** **NA**

Physician Name (Print Legibly)

Physician Signature (MD)

ID#

Date Signed

DISCHARGE PROGRESS NOTE

Discharge Date:

Discharge Diagnoses:

Medication(s):

Diet:

Limitation of Activity:

Follow-Up:

PHYSICIAN NAME (Print Legibly)

PHYSICIAN SIGNATURE / MD

ID#

DATE SIGNED