

Must be completed by a Physician's office and  
signed by physician at the time of the Pre/Operative appointment  
Please fax to: 410-363-7188 **and** 410-356-0309

HISTORY AND PHYSICAL \_\_\_\_\_

PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ RACE: \_\_\_\_\_

DATE: \_\_\_\_\_ SURGEON: DOUGLAS C. MC CORKLE, MD

INDICATIONS / SYMPTOMS FOR PROCEDURE: \_\_\_\_\_

CURRENT MEDICATIONS / DOSAGES: (REQUIRED) \_\_\_\_\_

ALLERGIES / MEDICATION REACTION: (REQUIRED) \_\_\_\_\_

PAST MEDICAL / ANESTHESIA HISTORY: (REQUIRED) \_\_\_\_\_

ASSESSMENT OF MENTAL STATUS: (REQUIRED) \_\_\_\_\_

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS: (REQUIRED) \_\_\_\_\_

LMP: (REQUIRED) \_\_\_\_\_ TYPE OF CONTRACEPTIVE: (REQUIRED) \_\_\_\_\_

PHYSICAL EXAMINATION:				COMMENTS
HEENT _____	NORMAL _____	ABNORMAL _____	_____	_____
HEART _____	NORMAL _____	ABNORMAL _____	_____	_____
LUNGS _____	NORMAL _____	ABNORMAL _____	_____	_____
ABDOMEN _____	NORMAL _____	ABNORMAL _____	_____	_____
MOUTH _____	NORMAL _____	ABNORMAL _____	_____	_____
TEMP _____	B/P _____	PULSE _____	DATE OF LMP _____	

MEDICALLY CLEARED FOR PROCEDURE: \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_, M.D.