The SURGICENTER of BALTIMORE

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.