Miami SURGICAL Center

ADULT HISTORY AND PHYSICAL

TO BE COMPLETED BY PATIENT
Please answer every question with a check

Yes ( ) No ( ) High blood pressure?
Yes ( ) No ( ) Have you had a stroke?
Yes ( ) No ( ) Dizziness?
Yes ( ) No ( ) History of falls?
Yes ( ) No ( ) Chest pain-angina?
Yes ( ) No ( ) Heart Attack(s) or other cardiac history
Yes ( ) No ( ) Mitral Valve Prolapse?
Yes ( ) No ( ) Heart Murmur?
Yes ( ) No ( ) Palpitations, irregular or fast heartbeats?
Yes ( ) No ( ) Rheumatic fever?
Yes ( ) No ( ) Eyes, ears, nose or throat problems?
Yes ( ) No ( ) Hearing problem or hearing aide (s)?
Yes ( ) No ( ) Vision problems?
Yes ( ) No ( ) Shortness of breath?
Yes ( ) No ( ) Bronchitis, a chronic cough?
Yes ( ) No ( ) Asthma or Hayfever?
Yes ( ) No ( ) A cold in the past 2 weeks?
Yes ( ) No ( ) Pneumonia or other lung problems?
Yes ( ) No ( ) Emphysema?
Yes ( ) No ( ) Tuberculosis?
Yes ( ) No ( ) Diabetes?
Yes ( ) No ( ) Thyroid trouble?
Yes ( ) No ( ) Gastrointestinal problems?
Yes ( ) No ( ) Gallbladder trouble?
Yes ( ) No ( ) Jaundice, Hepatitis or Liver trouble?
Yes ( ) No ( ) Kidney problems?
Yes ( ) No ( ) Urinary problems?
Yes ( ) No ( ) Anemia?
Yes ( ) No ( ) Blood transfusions?
Yes ( ) No ( ) Tendency to bruise?
Yes ( ) No ( ) Back pain or injury?
Yes ( ) No ( ) Slipped disc or Sciatica?
Yes ( ) No ( ) Frequent leg cramps or legs go to sleep?
Yes ( ) No ( ) High fever?
Yes ( ) No ( ) Polio, paralysis or Meningitis?
Yes ( ) No ( ) Convulsions or epilepsy?
Yes ( ) No ( ) Sickle Cell anemia?
Yes ( ) No ( ) Vitamins, minerals or herbal supplements?
Yes ( ) No ( ) Excessive alcohol/recreational drug use?
Yes ( ) No ( ) Do you smoke?
Yes ( ) No ( )Do you have dentures, loose teeth or caps?
Yes ( ) No ( ) Latex Allergy?
Yes ( ) No ( ) Mental Illness/ Depression
Other? Explain

Please identify any previous operations/ Anesthesia/ or any complications from surgery in the past

1.
2.
3.
4.

Patient Signature _____

List all known allergies/ sensitivities:

_____

_____

_____

List current medications & dosages:

_____

_____

_____

Family History of Illness:

_____

_____

_____

Chief complaint for today's visit:

_____

_____

_____

Accident? Yes _____ No_____
If Yes:
Work?_____ Home? _____ School? _____

Explain:_____

_____

_____

Ht: _____ Wt: _____
Last Menstrual Period: _____

Notes: _____

_____

For medical personnel only:
Reviewed by Nurse
Nurse Signature: _____
1. Reviewed by M.D. for History & Physical
2. See Anesthesia pre-op evaluation for physical
3. Review of Systems performed by M.D.
4. Physician reviewed anesthetic status of patient prior to procedure
5. Patient verbalizes understanding of H&P and proposed surgery
6. M.D. Signature _____