

**THE SURGERY CENTER OF THE MAIN LINE**

Fax completed form to 484-586-0170

**PREOPERATIVE HISTORY & PHYSICAL EXAMINATION**

***TO BE USED FOR:***

**DEEP SEDATION & GENERAL ANESTHESIA**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

PROPOSED SURGICAL PROCEDURE: \_\_\_\_\_

**MEDICAL & SURGICAL HISTORY**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ PULSE \_\_\_\_\_

GENERAL

EENT

HEART

LUNGS

ABD

EXT

NEURO

PELVIC (if applicable)

**ALLERGIES**

**MEDICATIONS**

RR \_\_\_\_\_ BP \_\_\_\_\_ TEMP \_\_\_\_\_

LAB \_\_\_\_\_ EKG \_\_\_\_\_ X-RAY \_\_\_\_\_

**IMPRESSION/PLAN**

\_\_\_\_\_  
Physician's Signature Date

\_\_\_\_\_  
Reviewed by Physician, No Change, Date  
Treatment still indicated