

Surgical Associates of Austin, P.A.

Markus • Mayer • Ashworth • Ching • Esquivel • Allred

History and Physical Form (Please print neatly)

Chart # _____

Please complete numbers 1 through 16 prior to returning form to receptionist. Thank you.

Date: _____

1. Patient Name: _____ Age: _____ Sex: ☐ M ☐ F
Last First Middle

2. Chief Complaint (nurse to complete): _____

3. Other Physicians involved in your care: Primary Care: _____

Specialists: _____

4. Drug Allergies: ☐ None ☐ Yes If Yes, List drugs: _____

5. Medications: ☐ None ☐ See attached list if more than four (include aspirin, Motrin, etc.) _____

6. Other Medical Problems: ☐ None
☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Diabetes ☐ Heart Murmur
☐ Prior Heart Attack ☐ History of Stroke ☐ Emphysema ☐ Cancer (Type) _____
☐ Mitral Valve Prolapse ☐ High Cholesterol / Lipids ☐ Bronchitis ☐ Arthritis
☐ Heart Rhythm Problem ☐ Clots in Leg Veins ☐ Asthma ☐ Seizures
☐ Other: _____

(Doctor's Notes): _____

7. Previous Operations (with last two digits of approximate year) ☐ None
☐ Heart Valve _____ ☐ Groin Hernia _____ ☐ C-Section(s) _____ ☐ Arthroscopy _____
☐ Total Joint _____ ☐ Other Hernia _____ ☐ Breast Biopsy(ies) _____ ☐ Spine Surgery _____
☐ Gallbladder _____ ☐ Colon Surgery _____ ☐ Mastectomy _____ ☐ Thyroid _____
☐ Appendectomy _____ ☐ Hysterectomy _____ ☐ Coronary Artery Bypass _____ ☐ Cataract _____
☐ Other: _____

(Doctor's Notes): _____

8. If female, date of last normal menstrual period: _____ 9. Are you Postmenopausal? ☐ Yes ☐ No

10. Alcohol: ☐ None ☐ Frequency: _____ 11. Tobacco: ☐ None ☐ Frequency: _____ 12. History of IV Drug Use: ☐ None ☐ Frequency: _____

13. Other Current Problems: ☐ None
☐ Chest Pain (Heart) ☐ Cough ☐ Significant Weight Loss ☐ Bleeding Tendency
☐ Irregular Heart Beat ☐ Coughed Up Blood ☐ Change in Bowel Habits ☐ Slurred Speech
☐ Shortness of Breath with Exertion ☐ Wheezing ☐ Blood in Stool Recently ☐ Urinary Problems
☐ Shortness of Breath at Night ☐ Constipation ☐ Diarrhea ☐ Weakness (Arms / Legs)
☐ Other: _____

(Doctor's Notes): _____

14. Names and ages of children: _____

15. Family History of: ☐ None ☐ Adopted
☐ Breast Cancer ☐ Ovarian Cancer ☐ Lung Cancer ☐ Colon Cancer ☐ Prostate Cancer ☐ Thyroid Cancer
☐ Melanoma ☐ Skin Cancer ☐ Throat Cancer ☐ Cervix Cancer ☐ Lymphoma ☐ Leukemia
☐ Multiple Myeloma ☐ Other Cancer: _____
☐ Early Age Heart Attack ☐ High Blood Pressure ☐ Diabetes ☐ Hemophilia or significant bleeding history
☐ Strokes ☐ Clots in the leg veins ☐ Gallbladder Disease

16. I will absolutely refuse blood transfusions under any circumstances: ☐ Yes ☐ No
☐ Other: _____

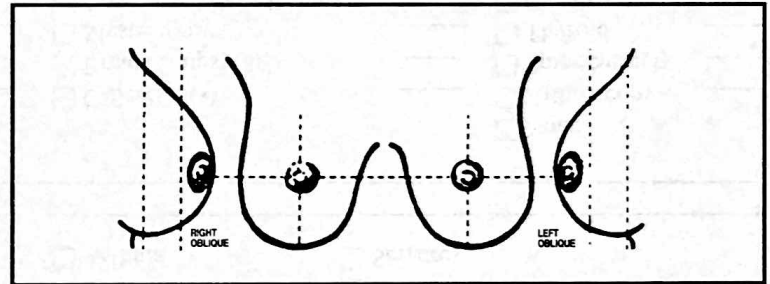
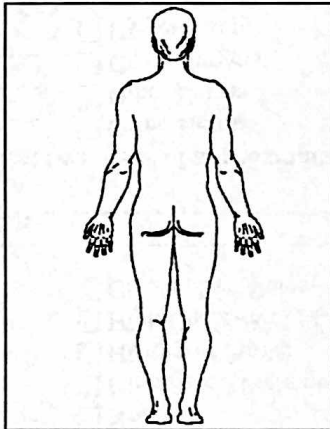
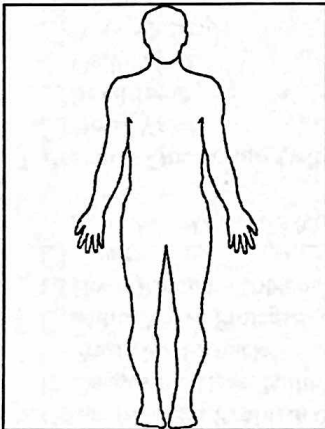
FOR OFFICE USE ONLY

Patient Name: _____ Chart # _____

Date: _____

Present Illness:**Physical Exam:**

Blood Pressure _____ Weight _____ Height _____ Heart Rate _____

GENERAL☐ Alert ☐ Active ☐ Ambulatory ☐ Other _____**EXTREMITIES**☐ Normal _____**HEENT, NECK**☐ Normal _____**HEART**☐ Normal _____**LUNGS**☐ Normal _____**BREAST**☐ Normal ☐ Not Examined _____**ABDOMEN**☐ Normal _____**ADENOPATHY**☐ Normal _____**GENITALS**☐ Normal ☐ Not Examined _____**PELVIC**☐ Normal ☐ Not Examined _____**RECTAL**☐ Normal ☐ Not Examined _____**Impression Plan:****PREOP ORDERS**☐ Routine ☐ As Listed Below _____**Hospital** ☐ Brack ☐ SAMC ☐ Seton ☐ Seton NW ☐ St. D ☐ Other _____**Anesthesia** ☐ GEN ☐ Regional ☐ Local ☐ MAC ☐ Special ☐ Need Assistant**Laboratory** ☐ CBC ☐ UA ☐ Lytes ☐ Liver Profile ☐ Type & Screen☐ Amylase ☐ BUN, Creatinine ☐ PT / PTT ☐ Other _____NPO D Midnight _____ ☐ CXR ☐ EKG with interpretation by _____☐ Type & Crossmatch _____ Units ☐ PRBC's _____ Units ☐ FFP _____ Units

Consent for _____

Markus • Mayer • Ashworth • Ching • Esquivel • Allred _____ M.D.