FORM D

Manhattan Eye, Ear & Throat Hospital

HISTORY & PHYSICAL

Patient Name:_____ Date of Surgery:_____

Requesting MD: _____ Planned Procedure: _____

Chief Complaint _____
History of Present Illness: _____

Past Surgical History: _____

Medications	Dose	Frequency

Medical History	NEG	POS	COMMENT IF POSITIVE
Hypertension/Heart	☐	☐	
COPD/Asthma/Sleep Apnea	☐	☐	
Renal Failure/Dialysis	☐	☐	
Bleeding/Blood Disorder	☐	☐	
Periph. Vas. Dis/Claudication	☐	☐	
Communicable Disease (Hepatitis)	☐	☐	
Cancer	☐	☐	
Other	☐	☐	

Allergies _____

History of Anesthesia reaction: Yes ☐ No ☐

Tobacco _____ PPD _____
Alcohol _____ DPD _____

Family/Social Hx: _____

Recreational Drugs: _____
Herbal Drugs: _____

REVIEW OF SYSTEMS

	Neg	Positive *(check if positive)*
Constitu.	☐	☐ Anorexia ☐ Fatigue ☐ Fever ☐ Weight Loss
Cardio	☐	☐ Angina ☐ DOE ☐ Orthopnea ☐ Edema ☐ Palpitations ☐ Syncope
Resp	☐	☐ Cough ☐ Dyspnea ☐ Pleuritic chest pain ☐ Other _____
Gastro	☐	☐ Gerd ☐ Vomiting ☐ Diarrhea ☐ Ulcer ☐ Dysphagia
GU	☐	☐ Dysuria ☐ Frequency ☐ Incontinence ☐ Hematuria
Neuro	☐	☐ Seizure ☐ Migraine ☐ Other
GYN:		Last Menstrual Period:_____

REVIEW OF SYSTEMS CONT.

	Neg	Positive *(check if positive)*
Skin	☐	☐ Rash ☐ Ulcers ☐ Other _____
Hemo	☐	☐ Easy bruising ☐ Hemoptysis ☐ Epistaxis ☐ Melena
Endo	☐	☐ Diabetes ☐ Thyroid Dis ☐ Heat/cold intolerance
Psych	☐	☐ Depression ☐ Anxiety
M/Skel	☐	☐ Joint Pain ☐ Back pain ☐ Arthritis
ENT	☐	☐ Decreased hearing ☐ Decreased Vision ☐ Blind

IS PREGNANCY A POSSIBILITY? ☐ Yes ☐ No _____

Height: ____ Ft ____ In	Weight: ____ Kg	BP:	P:	R:	Pain (0-10):

Physical Exam	WNL	Patient Refused	Explanation of Abnormal Findings	Other Comments
1. General	☐	☐		
2. Skin	☐	☐		
3. HEENT	☐	☐		
4. Neck	☐	☐		
5. Cardio	☐	☐		
6. Chest/Lung	☐	☐		
7. Abd	☐	☐		
8. Extremities	☐	☐		
9. Neuro	☐	☐		
10. Nodes	☐	☐		
11. Breasts Deferred ☐	☐	☐		
12. Rectal/Pelvic Deferred ☐	☐	☐		
13. PAP SMEAR	☐ PERFORMED		☐ DEFERRED ☐ REFUSED	

DX SURGICAL INDICATION	_____
PLAN / PROPOSED TREATMENT	_____

Date: _____ **Examining/Consulting Physician Signature:** _____

If not performed by MEETH credentialed physician: I attest that the above history & physical is current and accurate.

Date: _____ **Admitting Surgeon Signature:** _____

AMBULATORY SURGERY HISTORY & PHYSICAL MUST BE PERFORMED NO EARLIER THAN THIRTY (30) DAYS PRIOR TO SURGERY

INPATIENT/SDA HISTORY & PHYSICAL MUST BE PERFORMED NO EARLIER THAN SEVEN (7) DAYS PRIOR TO SURGERY

Update: If the date of the History & Physical is earlier than seven (7) days before the date of surgery, complete the following section.

☐ Patient checked today & there is no change in the History & Physical

☐ History & Physical has changed (Please see attached): _____

Date: _____ **Physician Signature:** _____

Fax to (866) 231-1027