THE SURGERY CENTER OF FAIRBANKS

NAME: ________________________________ DOB: ________ AGE: _____ ☐Female ☐Male

Chief Complaint: ____________________________________________________________

HISTORY OF PRESENT ILLNESS: __________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## PAST MEDICAL HISTORY

**SURGICAL HISTORY**: PROCEDURE: DATE PROCEDURE: DATE

| PROCEDURE | DATE | PROCEDURE | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

ILLNESSES (please circle) HTN DIABETES CAD ASTHMA GERD HYPERCHOLESTEROL

OTHER: ______________________________________________________________

| MEDICATIONS | DOSE/ FREQUENCY | REASON | MEDICATIONS | DOSE/ FREQUENCY | REASON |
|---|---|---|---|---|---|
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| | | | | | |

| DRUG ALLERGY | REACTION |
|---|---|
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| | |

## REVIEW OF SYSTEMS (please circle)

| | | | | | |
|---|---|---|---|---|---|
| Headaches | Seizures | Dysuria | Neuropathy | Dizziness | Coronary Disease |
| Blurred vision | Hepatitis A B C | Blackout spells | Nausea/Vomiting | CVA | Shortness of Breath Productive |
| cough | Pulmonary Disease | Chest pain | Thyroid Disease | HIV | Blood Dyscrasia |
| Abdomen Pain | Pregnancy | Problems with Anesthesia | | | |

## PHYSICAL EXAM

BP__________ RESP _______ PULSE_______ TEMP______ WEIGHT __________ HEIGHT _________

HEENT:_______________________________________________________________________

NECK:________________________________________________________________________

CHEST:_______________________________________________________________________

HEART:_______________________________________________________________________

ABDOMEN:_____________________________________________________________________

MUSCULOSKELETAL:_____________________________________________________________

NEUROLOGIC:__________________________________________________________________

DIAGNOSTIC TEST:_____________________________________________________________

ASSESS/PLAN:_________________________________________________________________

PHYSICIAN SIGNATURE: ____________________________ _________Date/Time:____________________________

H&P UPDATE NO CHANGES ☐ Date/Time:____________________