CHILDREN'S EYE CARE OF CONNECTICUT

Please schedule a pre-op physical with the PCP. This has to be done within 30 days prior to the surgery otherwise surgery will be canceled. Bring this form to the appointment so they can fill it out and fax back ASAP.

SHORT FORM HISTORY& PHYSICAL

Document information in boxes indicated or note that data is detailed on the reverse side of this form

UPON COMPLETION, PLEASE FAX TO: **_860 - 359 - 2540**_____

Admitting MD	NAME:
Diagnosis	Date of Procedure
PROPOSED PROCEDURE (if applicable)	
HISTORY – PRESENT COMPLAINT	
Current Medications	

PAST MEDICAL HISTORY	FAMILY HISTORY	SOCIAL HISTORY
Allergies: ☐ Yes ☐No Previous Surgery/Hospitalizations: ☐ Yes ☐No Immunizations Up to Date: ☐ Yes ☐No	Anest. Rxn.: ☐ Yes ☐No Bleeding: ☐ Yes ☐No Other Pertinent:	Pertinent ☐ Yes ☐No

R.O.S. – any problems noted on reverse side	SYSTEM	PHYSICAL EXAMINATION HEIGHT _____ cm WEIGHT _____ kg			
			Examined and WNL	Examined and Not WNL	Exam Deferred	Abnormalities/deferment explained here by system number
1 ☐	1. Eyes	1	☐	☐	☐	
2 ☐	2.. Ears, nose, mouth	2	☐	☐	☐	
3 ☐	3. Cardiovascular	3	☐	☐	☐	
4 ☐	4. Respiratory	4	☐	☐	☐	
5 ☐	5. Gastrointestinal	5	☐	☐	☐	
6 ☐	6. Genitourinary	6	☐	☐	☐	
7 ☐	7. Musculoskeletal	7	☐	☐	☐	
8 ☐	8. Skin	8	☐	☐	☐	
9 ☐	9. Neurologic	9	☐	☐	☐	
10 ☐	10.Psychiatric	10	☐	☐	☐	
11 ☐	11.Hematologic/Lymphatic	11	☐	☐	☐	
12 ☐	12.Other	12	☐	☐	☐	

LABORATORY **Hgb/Hct: (if applicable)**
Other:

MD Signature_____ **Date**_____
Time_____

DO NOT WRITE BELOW – FOR DAY OF SURGERY/PROCEDURE ONLY

Patient has been examined – H&P reviewed – No changes ☐
Patient has been examined – H&P reviewed – Changes noted below:

_____

MD Signature _____ ***Date*** _____ ***Time*** _____

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ADDITIONAL INFORMATION: This area is used to document information which would not fit on the other side, such as positives from the review of systems (R.O.S.)

OPERATIVE NOTE

Pre-Op Diagnosis:

Post-Op Diagnosis:

Operation / Procedure:

Surgeon: Assistant:

Anesthesiologist: Anesthesia:

Fluids:

EBL:

Drains: ☐ None

Findings:

Specimens: ☐ None

Patient's Condition Post-Op: ☐ Stable

MD Signature _____ Date _____ Time _____