*Chief Complaint/History of Present Illness _____

_____

ASA score (if applicable)_____

*Allergies _____

*Medications Dosage Frequency

_____

_____

*Past Significant Surgery OR Illness _____

_____

Family History _____

Tobacco_____Alcohol_____Drugs _____

_____

VITAL SIGNS AND MENTAL STATUS AS PER NURSING ASSESSMENT

HEENT _____

_____

*Heart_____

_____

*Lungs _____

_____

Breasts _____

_____

Abd/Pelvic/Rectal _____

_____

_____

Neuro _____

_____

Extremeties _____

_____

Skin _____

Other Findings _____

_____

*Admission Diagnosis _____

*Planned Treatment/Procedure_____

_____

Physician_____ _____ _____ _____

(Signature) (Printed Name) (Date) (Time)

***Complete all starred lines for ALL patients. Complete all other lines pertinent to patients planned procedure or medical condition.**

UPMC LIFE CHANGING MEDICINE

OUTPATIENT PROCEDURE HISTORY AND PHYSICAL

PATIENT IDENTIFICATION