Summit Surgical
History & Physical

___Dr. Loewen ___Dr. Severud ___Strader

Name: _____ Date of Birth: _____

Primary Care Physician:_____Location/Phone Number_____

Is this procedure related to an accident? ___Yes ___No Date of Accident: _____

Medical History

Lung	**Vascular**	**GI/GU/Systemic**	**Systemic/Social**
___ Recent Bronchitis	___Congestive Heart Failure	___Heartburn/Hiatal Hernia	___Convulsions/Epilepsy
___Emphysema	___High Blood Pressure	___Bladder Problems	___Parkinson's (tremors)
___Asthma	___Mitral Valve/Murmur	___Prostate Problems	___Seizures ___Paralysis
___Chronic/A.M Cough	___Heart Attack ___yr	___ Ulcers	___Thyroid Disorder
___Recent Pneumonia	___Recent Chest Pain	___Stomach Problems	___AIDS Exposure
___Shortness of Breath	___Irregular/Fast Heart Beat	___Liver Problems	___Hepatitis:Type_____
___Tuberculosis Exposure	___Cardiac Pacemaker	___Kidney Failure/Dialysis	___Sleep Apnea □Use CPAP
___Recent Infection "Cold"	___ Cardiac Defibrillator	___Bowel Problems:	___Alcohol use
___Do you Smoke	___Stroke or Mini Stroke	□ Polyps □ Constipation	How often_____
___Have you ever smoked?	**Mental Health**	□ Diarrhea □ Hemorrhoids	___ Street Drug use
How much: _____	___ADD	□ Rectal Bleeding	___Diabetes- Controlled by
How Long: _____	___Depression ___Anxiety	□ Family History Colon Cancer	□ Diet □ Insulin
	___Bipolar Disorder	___Arthritis	□ Oral Medication

List any medical conditions not listed: _____

List ALL Current Medications, Doses and how often you take them (include Vitamins, Herbs & over the counter Medications) _____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies to medications? □ No □ Yes: Please list allergies and reactions:

_____ _____ _____ _____ _____ _____

List prior surgeries and year performed: _____

_____

FAMILY HISTORY: Father: If deceased, at what age? _____Medical Problems of Father:_____

Mother: If deceased, at what age? ____Medical Problems of Mother:_____

List Medical Problems of Brothers and Sister: _____

Have you or your family had any complications with anesthesia? □No □Yes What?_____

_____(do not fill out below this line – to be completed by provider)_____

PHYSICAL EXAMINATION

WT: _____ HT_____VS: T: _____ P: _____ R: _____ BP: _____ BMI_____

Chief Complaint:_____Diagnosis: _____

History or Present Illness:_____

Please describe abnormalities below

Please check each item:	Normal	Abnormal	N/A	
General Appearance	□	□	□	_____
Eyes, Ears, Nose, Throat	□	□	□	_____
Heart	□	□	□	_____
Lungs	□	□	□	_____
Abdomen	□	□	□	_____
GU System	□	□	□	_____
Extremities	□	□	□	_____
Spine/Neck	□	□	□	_____
Neurological	□	□	□	_____

Plan: _____Indications for Procedure:_____

RX Given: Percocet Norco Naprosyn Vistaril Tramadol_____

F/U Appt._____ PT F/U appt._____

□ **Risks, Benefits and alternatives to surgery discussed with patient**

Provider Signature/ Date/time: _____

Revised: 09/09, 08/10,9/10, 7/2012, 9/2014, 10/6/2015
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