the SUMMIT
Institute for Orthopedics, Spine & Human Movement

PATIENT LABEL

HISTORY & PHYSICAL

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 Heartbeat	____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? ☐ YES ☐ NO Please list allergies & 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 sisters: ____

Have you or your family had any complications with anesthesia? ☐ YES ☐ NO 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 of 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 Tramdol ______________________________________

Risks, benefits and alternatives to surgery discussed with patient

Provider signature: ____ Date/Time: _____________ Revised 06/2022