



WHATCOM EYE SURGEONS

A Division of Northwest Eye Surgeons of Seattle

History and Physical

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____ ☐ M ☐ F

Informant Name: _____ Relationship to patient: _____

Primary Language: _____ Interpreter: ☐ Yes ☐ No Interpreter Name: _____

Chief Complaint: _____

Allergies & Reactions: ☐ None ☐ See Attached Current Medications: ☐ None ☐ See Attached

Medical History & Review of Systems

Bleeding Tendencies: ☐ None ☐ Other _____

Transmissible Disease(s): ☐ None ☐ Other _____

Neurological: ☐ None ☐ Seizure Last seizure: ____/____/____ ☐ Other: _____

Cardiovascular: ☐ None ☐ Other _____

Respiratory: ☐ None ☐ Other _____

Gastrointestinal: ☐ None ☐ Other _____

Musculoskeletal: ☐ None ☐ Other _____

Metabolic: ☐ None ☐ Other _____

Genito-Urinary: ☐ None ☐ Dialysis ☐ Possible Pregnancy ☐ Flomax Use ☐ Other _____

Psychological: ☐ None ☐ Other _____

Social History

Alcohol Use: ☐ Never/No ☐ Rare/Social ☐ Current Daily Use - how much _____ ☐ Recovering Alcoholic

Smoker: ☐ No ☐ Yes # of years _____ #packs per day _____

Who would be driving or accompanying you home from surgery? _____

Primary Care Provider: _____ PCP Office Phone #: _____ - _____ - _____

Physical Examination

Vital Signs: Temp _____ BP _____ Pulse _____ RR _____ Weight _____ Height _____

General Appearance: _____

Head/Eyes/Ears/Nose/Throat: _____

Neck: _____

Heart: _____

Lungs/Chest: _____

Abdomen: _____

Extremities: _____

Skin: _____

Neurologic: _____

Diagnosis: _____

Procedure/Plans: _____

Cleared for surgery in an ambulatory setting with local anesthesia and moderate sedation: ☐ Yes ☐ No, explain _____

Signature: _____ Date: ____/____/____ Time: _____