PATIENT PRE-OP/HISTORY & PHYSICAL FORM

*NOTE: THIS FORM/REQUEST IS ONLY VALID FOR 30 DAYS.
*PLEASE ATTACH MOST RECENT NOTES REGARDING PATIENTS MOST RECENT VISIT
*FAX NOTES, ALONG WITH THIS FORM TO OUR DIRECT FAX NUMBER PROVIDED ➡

7888 GATEWAY BLVD E, SUITE B
EL PASO, TX 79915
PHONE: (915)315-2584, FAX: (915)317-7080

PATIENT NAME: ______________________ DOB: ____/____/____ SEX: ________
PROCEDURE: ______________________ DATE OF PROCEDURE: ____/____/____
DIAGNOSIS: ______________________
CPT CODES: ______________________
SURGEON PERFORMING PROCEDURE: SAPNA TIBREWAL

LOCATION:
EAST EL PASO SURGERY CENTER ☐ EL PASO CHILDREN'S HOSPITAL ☐

SURGICAL HISTORY:

HISTORY OF ADVERSE REACTION TO ANASTHESIA: YES ☐ NO ☐ If marked yes, please comment

KNOWN ALLERGIES & REACTIONS:
NKDA: ☐

MEDICATION:

*Make sure to bring a list of all medications, vitamins, supplements (including herbal), and drops on the date of the procedure.

PHYSICAL EXAMINATION & VITAL SIGNS

HEIGHT: ____________cm | TEMPERATURE: ____________ | HEART RATE: ____________
WEIGHT: ____________Kg | BLOOD PRESSURE: ____/____ | RESPIRATORY: ____________

REVIEW OF SYSTEMS	NORMAL	ABNORMAL	COMMENTS
Constitutional	☐	☐	
Head(Eye, Ear, Nose, & Throat)	☐	☐	
Breast	☐	☐	
Respiratory	☐	☐	
Cardiovascular	☐	☐	
Gastrointestinal	☐	☐	
Genitourinary	☐	☐	
Integumentary	☐	☐	
Hematologic/lymphatic	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Endocrine	☐	☐	
Psychiatric/Behavioral	☐	☐	

MD/Examiner's Signature______________________ **Date**____/____/____

PRE-OP/HISTORY & PHYSICAL FORM *(Continued...)*

DRISHTI KIDZ EYE CARE
7888 GATEWAY BLVD E, SUITE B
EL PASO, TX 79915
PHONE: (915) 315-2584
FAX: (915) 317-7080

PATIENT NAME: ______________________________ **DATE OF BIRTH:** _____/_____/_____

PHYSICAL EXAM	NORMAL	ABNORMAL	COMMENTS
Head(Eye, Ear, Nose, Throat)	☐	☐	
Heart	☐	☐	
Breast	☐	☐	
Lungs	☐	☐	
Abdomen	☐	☐	
Pelvic and Genitalia	☐	☐	
Extremities	☐	☐	

Assessment:

☐ Patient may proceed with planned surgery as scheduled for _____/______/______

☐ Additional pertinent information attached

☐ Pending clearance from ______________________ List name/specialty ____________________

Signature of Parent/Guardian ______________________________ **Date** _____/_____/_____

MD/Examiner's Signature ______________________________ **Date** _____/_____/_____

PLEASE FAX FORMS IMMEDIATELY UPON COMPLETION TO 915-317-7080.
FAILURE TO RECEIVE FORMS AT LEAST ONE WEEK PRIOR TO SURGICAL DATE MAY RESULT IN CANCELLATION, OR NEED TO RESCHEDULE THE PROCEDURE.
THANK YOU.