

History and Physical

Patient Name: _____

A/K Acct #: _____

DOB: _____

Male Female

L.M.P. _____

History of Present Illness: Poor Vision due to cataract Right eye Left Eye
 Astigmatism Retained lens material Glaucoma

Allergies/Reactions: _____

Current Medications: _____

Past Medical History: HTN IDDM / NIDDM Hyperlipidemia Arthritis Hypothyroidism

Surgical History: _____

PHYSICAL EXAM			
Height:	Pulse:	Temperature:	
Weight:	BP:	Resp:	O ₂ sat:
MENTAL STATUS	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Alert <input type="checkbox"/> Orientated		
HEENT	<input type="checkbox"/> Hard of hearing <input type="checkbox"/> Cough <input type="checkbox"/> Dry mouth		
CHEST	Lungs clear <input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> SOB		
HEART	<input type="checkbox"/> S ₁ <input type="checkbox"/> S ₂ <input type="checkbox"/> Regular Rhythm <input type="checkbox"/> Irregular Rhythm		
ABDOMEN	<input type="checkbox"/> Soft non-tender <input type="checkbox"/> Bowel Sounds <input type="checkbox"/> Y <input type="checkbox"/> N		
EXTREMITIES	Peripheral Edema <input type="checkbox"/> Y <input type="checkbox"/> N		
OTHER PERTINENT INFORMATION			
DIAGNOSIS: <input type="checkbox"/> Cataract <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other _____			

Proposed Surgery / Procedure: Cataract extraction with lens implant ___ R ___ L LRI ECP
 Other _____

Cleared for Surgery: Yes No

Physician Signature: _____ Date: _____