HISTORY & PHYSICAL EXAMINATION (*Must be completed within 30 days of surgery*)

TODAY'S DATE: ______________________________ SURGERY DATE: ____________________

PATIENT NAME: ______________________________ DOB: ______________ PT #:___________

Present Condition or Illness: __________________

____

Family History:______________________________

____

____

Past History:________________________________

____

____

Allergies: ________________________________

____

Eyes:_______________________________

Ears:_______________________________

Nose:_______________________________

Throat:______________________________

Mouth:______________________________

Neck:_______________________________

Heart:______________B/P:______________

Lungs:_______________________________

____

Abdomen: ___________________________

____

Extremities:___________________________

____

Reflexes:______________________________

____

Other:_______________________________

____

REVIEW OF SYSTEMS	**FINDINGS** Neg.	Positive
ENT	_____	______
CARDIORESPIRATORY	_____	______
GASTROINTESTINAL	_____	______
GENITOURINARY	_____	______
NEUROMUSCULAR	_____	______

*If positive, describe:____

Current Medications: ____

____

FAX BACK TO: ADLER PODIATRY CLINIC, PLLC

PHONE: (904) 731-1711 FAX: (904) 731-9270

Clearance for Surgery: Yes: _____ No: ______ If no, please explain: _____________________

____

(Print) Dr.'s Name: ____ Office Phone: _____________

Dr.'s Signature: ____Date: ____________________