Dignity Health
St. Joseph's Hospital and Medical Center

Outpatient Surgery Center
Recovery Care Center

Patient's Name ______
Admitting Diagnosis: ______
History of Present Illness: ______

PAST HISTORY

Allergies: ______

Medications: ______

______

Surgical History: ______

______

Patient Family Social History: ______

PHYSICAL EXAM

Check appropriate box, describe abnormal findings

	Normal	Abnormal	Deferred	Comments
Skin	☐	☐	☐	______
HEENT	☐	☐	☐	______
Heart	☐	☐	☐	______
GI/GU	☐	☐	☐	______
Lungs	☐	☐	☐	______
Abdomen	☐	☐	☐	______
Musculoskeletal	☐	☐	☐	______
Neurological	☐	☐	☐	______
Other	☐	☐	☐	______

Impression: ______

______

Proposed Procedure: ______

______

Alternatives, risks and benefits of surgical procedure have been explained to patient ______ Yes ______ No

☐ Patient has been cleared for surgery in an ambulatory setting

Date: ______ Time: ______ Physician Signature: ______

No change since last exam ______ Physician Signature: ______
Date: ______ Time: ______

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