Fax to Dr. Minsky, DDS
(714) 363-5441

Whit Pres Fax:
562-464-5114

St Joseph Fax:
888-976-5803

Western Med Center
Fax: 714-953-3622

ENTIRE FORM MUST BE COMPLETED. The patient's name must be on this form.
By Law;
Patient's receiving general anesthesia must have a history and physical completed by a physician within 30 days of receiving general anesthesia.

CHIEF COMPLAINT HISTORY OF PRESENT ILLNESS: ______________________

ALLERGIES: ______________________

CORONARY RISK FACTORS:

1. Smoking ☐ Yes ☐ No
2. Diabetes Mellitus ☐ Yes ☐ No
3. Hypertension ☐ Yes ☐ No
4. High Cholesterol ☐ Yes ☐ No
5. Family History ☐ Yes ☐ No

PAST MEDICAL HISTORY:

HEART Disease: ______________________
LIVER Disease: ______________________
LUNG Disease: ______________________
KIDNEY Disease: ______________________
NEUROLOGIC Disease: ______________________
GI Disease: ______________________
GYN Disease: ______________________
SURGERIES (Specify): ______________________
OTHER (Medical Disease): ______________________

PRESENT MEDICATIONS:

____

____

PERTINENT LAB/X-RAY FINDINGS: ______________________

GENERAL: ______________________

PHYSICAL EXAMINATION: BP: ________ P: ________ Wt:. ________ Hgt: ________ Resp: ________

HEENT: ______________________
NECK: ______________________
LUNGS/CHEST: ______________________
BREASTS: ______________________
HEART: ______________________
ABDOMEN: ______________________
NEUROLOGIC: ______________________
SKIN: ______________________
RECTAL/PELVIC: ______________________
EXTREMITIES: ______________________

ADMITTING DIAGNOSIS: ______________________

____

Date: ________ **MD Signature:** ______________________ **M.D. Only**

MD Printed Name ______________________ **MD Phone** ________

This form must be signed by a physician only and include the patient name

Bring a completed copy of this form signed by a physician to the hospital on the day of surgery.

PATIENT NAME

____

FAXED or Mailed : ________