OUTPATIENT HISTORY AND PHYSICAL

(Valid for Outpatient visits only)

HISTORY

Chief Complaint: _____

History of Present Illness: _____

Medications Reviewed: ____

Allergies _____

Past Medical History / Previous Hospitalizations, Operations: _____

_____

Review of Systems: _____

_____

PHYSICAL EXAM

General Appearance: WDWN_____

Mental Status: Alert & Oriented: _____ Other: _____

EENT: Normocephalic: _____ Neck is supple: _____

Airway Examination: ☐ MOUTH OPENING greater than 3 cm, Soft palate, tonsillar fossae, uvula visualized, Thyroid-Mental distance 3 finger breadths

☐ Abnormality _____

Heart: No murmurs: _____ No gallops: _____ NSR: _____

Lungs: Clear to auscultation: _____ No consolidation percussed: _____

Abdomen: Soft: _____ No organomegaly: _____ No rebound: _____
No guarding: _____ Bowel sounds Normal: _____

GU: LMP: _____

Extremities: Normal _____ Other: _____

Neuromuscular: Normal _____ Other: _____

Lymphatics: Negative _____ Abnormal chain involved: _____

Other: _____

DIAGNOSIS: _____

PLAN: _____

FOR MODERATE SEDATION ONLY

ASA Class 1 No organic, physiologic, biochemical or psychiatric disturbance
ASA Class 2 Mild to moderate systematic disturbance that may or may not be related to the reason for surgery
ASA Class 3 Severe systemic disturbance that may or may not be related to the reason for surgery
ASA Class 4 Severe systemic disturbance that is life-threatening with or without surgery
ASA Class 5 Moribund patient who has little chance of survival but is submitted to surgery as a last resort (resuscitative effort)
Emergency Operation E Any patient in whom an emergency operation is required

ASA Class **(circle one)** 1 2 3 4 5 E

___ **Patient evaluation indicates appropriate for sedation / analgesia.**

___ **Patient re-assessed immediately prior to procedure.**

Planned Sedation: __ Local Anesthesia __Moderate Sedation __Deep Sedation __ General Anesthesia

_____ _____ _____
PHYSICIAN SIGNATURE **DATE** **TIME**

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