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Dear Provider, our mutual patient is having eye surgery at UCLA Stein Eye Institute.
Any existing H&P template that you already use is acceptable as long as it has ROS, exam, clearance statement, and signature. This below form can be used if you do not have a template.

History and Physical:	**H&P completed within one month of surgery date for all patients** Any existing template with these 4 elements is acceptable (example attached): 1) Review of systems 2) Physician exam 3) Statement of risk / clearance 4) MD signature / date (H&Ps done by NPs need MD cosign)
Type of Anesthesia:	**Our standard anesthesia: <u>Topical eye drops with IV sedation</u>** Surgeon to specify additional: ☐ Retrobulbar Block ☐ General Anesthesia
EKG:	Must be done within six months of surgery on all patients >50 years old. Any age patient with cardiac, renal, pulmonary disease, diabetes, or hypertension. Please fax EKG tracing, with interpretation and old EKG if indicated.
Pacemaker / Defibrillator:	Please send most recent pacemaker/AICD check. MUST BE within 6 months of surgery.
Stress Test/ Echocardiogram:	If the patient has had cardiac problems (AS, CAD, MI, CHF, MVP, heart surgery, angioplasty, cardiac stents, irregular heartbeat, pulmonary hypertension) please fax report of test results.
CBC:	Patients having had chemotherapy in last six months, history of renal failure, diabetes, anemia, or bleeding tendency
Creatine, Glucose Electrolytes, BUN:	Patients with diabetes, renal failure, is on diuretics, digoxin, steroids or with a pacemaker.
Thyroid Function:	If patient is hyper/hypothyroid.
Liver Function:	If patient has liver disease.
Sleep Study:	If patient has sleep apnea.
Chest Xray:	If patient has had recent pneumonia or CHF.

PATIENT MUST HAVE TRANSPORTATION ON THE DAY OF SURGERY—**NO EXCEPTIONS**.
PATIENT MUST HAVE AN ADULT PRESENT AT TIME OF CHECK IN FOR SURGERY. THEY NEED TO WAIT CLOSE BY TO TAKE PATIENT HOME AFTER SURGERY. TAXI / UBER / LYFT ARE NOT AN ACCEPTABLE FORM OF TRANSPORTATION OR YOUR SURGERY WILL BE CANCELLED

History & Physical Form

MD can use your own form or fill this out

Patient Label

Date of Examination: _______________________________

Allergies: ____

Medications: both prescription and over-the-counter (including doses):

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Alcohol ☐ No ☐ Moderate ☐ Heavy

Street drugs ☐ No ☐ Yes ___________________________

Blood/Fluid Precautions: ☐ No ☐ Yes ____________________________

Past Surgical History/ Type of Anesthesia/ Complications:

1. ____
2. ____
3. ____
4. ____
5. ____

HEENT:

Sleep apnea or airway compromise ☐ Yes ☐ No CPAP: ☐ Yes ☐ No

O2? ☐ Yes ☐ No

Cardiovascular:

Hypertension	☐ Yes	☐ No	If Yes, is well controlled? ______
Walk 1-2 blocks:	☐ Yes	☐ No	
Climb flight of stairs:	☐ Yes	☐ No	
Prior MI	☐ Yes	☐ No	
Palpitations	☐ Yes	☐ No	
Prior CHF	☐ Yes	☐ No	If Yes, when? ____________________
Angina	☐ Yes	☐ No	
Angioplasty	☐ Yes	☐ No	If Yes, when? ____________________
CABG	☐ Yes	☐ No	If Yes, when? ____________________
Arrythmia	☐ Yes	☐ No	If Yes, when? ____________________
PVD	☐ Yes	☐ No	
Able to lie flat	☐ Yes	☐ No	Number of pillows: ______________________________
Pacemaker	☐ Yes	☐ No	Last check date [ ] _______________________

Exercise Tolerance:

____

Respiratory:

COPD	☐ Yes	☐ No	
Chronic cough	☐ Yes	☐ No	
Productive	☐ Yes	☐ No	
Smoker	☐ Yes	☐ No	Pack-years: ____________________
Other:	____		

Gastrointestinal:

GERD	☐ Yes	☐ No	Controlled ☐ Yes ☐ No
Elevations of LFT's	☐ Acute	☐ Chronic	
Hepatitis	☐ Yes	☐ No	Type _________________________________
Other:	____		

Endocrine:

Diabetes	☐ Yes	☐ No
Graves	☐ Yes	☐ No
Hypothyroid	☐ Yes	☐ No

OB/Gyn:

Possibility of pregnancy ☐ Yes ☐ No

Last menstrual period: _______________________________

Renal:

Dialysis ☐ Yes ☐ No Number of years _______________________________

CRI ☐ Yes ☐ No

CNS:

CVA ☐ Yes ☐ No When? _________ Residual? _________

Seizures ☐ Yes ☐ No Date of last seizure __________________

Family History:

Family history of anesthetic complications ☐ Yes ☐ No

Physical Examination: BP ________ Pulse _________ RR ________ T ________ Wgt _______ Ht: _________

HEENT:

Lungs:

Heart: Rate/minute:_________________ Rhythm: __________________

Murmurs: ☐ Yes ☐ No If Yes, please attach last echo

Abdomen:

Extremities:

Neurological:

Laboratory: EKG ____________ Any change? ___________________ Date: _____________

ECHO __________ Ejection Fraction ________________ Date: _____________

Stress Test ____ Date: ____________

CBC: ____________________________________ Lytes: _________________________

LFTs: __________________________________ TSH: __________________________

Patient's medical condition is optimal for planned procedure: ☐ Yes ☐ No

Should patient stop taking Coumadin or any type of blood thinners? ☐ Yes ☐ No

If yes, how many days before the planned procedure?____

Recommendations:

____

____

Signature of examining physician: _______________________________________ Date of exam: _____________

Printed Name: ____ Telephone : _________________

H&P's done by nurse practitioners and/or physician assistant requires MD co-signature. Thank you.