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: *Topical eye drops with IV sedation*

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.

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**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**
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? _________________
Arrhythmia □ 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
- CRI: [ ] Yes [ ] No
- Number of years _____________________________

CNS:
- CVA: [ ] Yes [ ] No
- Seizures: [ ] Yes [ ] No
- When? __________ Residual? __________
- 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.