History and Physical Examination for Outpatient Surgery
To be completed by Primary Care Physician

Patient Name: ________________________________  Age:_____ Date: ____________

Proposed Surgery:_________________________________________________________

Surgeon:__Chris Byrne, DPM_____ Date:Time________________

Proposed Anesthesia: Monitored Anesthesia Care (MAC)  □  General  □  Spinal  □

History:

Allergies: ____________

Medications:_________________________________

_________________________________

PMH:_________________________________

_________________________________

PSH:____________________________

_________________________________

Social History:____________________

Smoker: Yes / No__________Pack years

Physician Comments:

_________________________________

Physical Exam:

Height:__________ Weight:__________

Vitals: T ___  P ___  R ___  BP ______

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<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
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<td>Heart</td>
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<td>Skin</td>
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Other: ___________________________ Yes ☐ No ☐

Is Patient Medically Stationary for this Proposed Surgical intervention?
Physician Signature: __________________________ Date: _____________

Please obtain a preoperative EKG following the guidelines below as well as provide requested preoperative laboratory testing if required prior to surgery:

**EKG** ☐

Males and females age 50+ need preoperative EKG.
Guidelines for repeat EKG:

a) Diabetic Patients:
   - EKG w/in 3 months if previous EKG was normal and no clinical symptoms.
   - EKG w/in 1 month if previous EKG was abnormal
b) Non-Diabetic Patients:
   - EKG w/in 6 months if previous EKG is abnormal and patient is asymptomatic
   - EKG w/in 1 year if previous EKG was normal and no symptoms.
Frequency to be determined based on activity level, CAD risk factors, type of surgery and clinical conditions

**Laboratory**
If your patient currently has laboratory studies that are within three months of the proposed study please send them by fax. We will fax over the appropriate lab work to your office. If you feel that your patient will need additional labs please add them to the requested studies.

☐ CBC
☐ Chem panel

*Thank you for participating in the preoperative clearance for our patient in common. If your office personnel will fax this completed form to our Templeton office location at 434-0119 it would be appreciated.*

*If you have any questions regarding the proposed surgical care to our mutual patient please don’t hesitate to call the office:*

San Luis Obispo  
(805)543-7788  
1551 Bishop Street, 210B  
San Luis Obispo, Ca 93401

Templeton  
(805)434-2009  
1101 Las Tablas Road, Suite K  
Templeton, Ca 93465