Charles P. Virden, M.D., F.A.C.S.

COSMETIC & RECONSTRUCTIVE PLASTIC SURGEON

PATIENT HISTORY & PHYSICAL

PATIENT HISTORY

NAME: _____ DOB: _____ AGE: _____ HT: _____ WT: _____

ALLERGIES: _____

PREVIOUS SURGERIES: _____

Anesthesia Problems:	Yes	No	Diabetes:	Yes	No
Heart Problems:	Yes	No	Kidney Problems:	Yes	No
High Blood Pressure:	Yes	No	Liver Problems:	Yes	No
Stroke/Circulatory Problems:	Yes	No	Thyroid Problems:	Yes	No
Bleeding Problems:	Yes	No	Digestive Problems:	Yes	No
Breathing problems:	Yes	No	Visual or Hearing Problems:	Yes	No
Seizures or Epilepsy:	Yes	No	Chronic Pain:	Yes	No Location: _____
Pregnant:	Yes	No	Do You Smoke?	Yes	No Amount? _____
			History of:	MRSA	C. diff VRE

List Current Medications and Supplements: _____

_____

Personal Physician: _____ Referring Physician: _____

Patient Signature: _____ Date: _____ Time: _____

PHYSICIAN'S PHYSICAL EXAMINATION

HEENT	WNL	☐
NECK	WNL	☐
LUNGS	WNL	☐
HEART	WNL	☐
BREAST	WNL	☐
ABDOMEN	WNL	☐
GU	WNL	☐
RECTAL	WNL	☐
NEURO	WNL	☐
EXTREMEMTIES	WNL	☐

NOTES: _____

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IMPRESSION/DIAGNOSIS: _____

PLAN: _____

_____

PHYSICIAN SIGNATURE: _____ M.D. Date: _____ Time: _____

NURSE'S NOTES

BP:_____ P:_____ R:_____ HEART & LUNGS CLEAR TO AUSCULTATION: YES NO PHOTOS TAKEN: YES NO

LABS ORDERED: CBC UA CHEM PANEL BUN CREAT LYTES BS PT/PTT AUTO-BLD CXR EKG

PRE & POST-OP INSTRUCTIONS REVIEWED: ☐ VERBAL WRITTEN

SURGERY FACILITY: _____ DATE: _____ TIME: _____

Rx TO PATIENT: _____

PATIENT POST-OP DRIVER & PHONE #: _____ PATIENT POST-OP PHONE #: _____

NOTES: _____

NURSE SIGNATURE: _____ R.N. Date: _____ Time: ____