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This form is for your physician to fill out and fax to Dr. Bruno (856) 205-0300

HISTORY AND PHYSICAL EXAMINATION

PATIENT'S NAME: _____ DOB: _____

AGE: _____ GENDER: M F ALLERGIES: _____

CHIEF COMPLAINT: _____

FAMILY HISTORY: _____

MEDICAL/SOCIALHISTORY: _____

MEDICATIONS: _____

REVIEW OF SYSTEMS: (COMPLETE EACH SYSTEM SEPARATELY AND ENSURE EVERY LINE CONTAINS A WRITTEN RESPONSE)

VITAL SIGNS: BP: _____ P: _____ RESP: _____ WEIGHT: _____ HEIGHT: _____

HEENT: _____

HEART: _____

LUNGS: _____

ABDOMEN: _____

EXTREMITIES: _____

NEURO: _____

PELVIC: _____

G.U./RECTAL: _____

INTEGUMENTARY: _____

PLAN: _____

Patient is medically cleared for surgery in an ambulatory care setting

SIGNATURE: _____ DATE: _____