CALIFORNIA ORBITAL
CONSULTANTS

Neuro-Ophthalmology, Oculoplastics and Orbital Surgery, Adult Strabismus
360 San Miguel Drive Suite 307 Newport Beach, CA 92660
Ph: 949-441-5058 F: 866-777-5972
www.myeyelidsurgeon.com

We are eager to help provide the safest outpatient surgery environment for your patient:

_____

Kindly provide the following at least TWO weeks prior to your patient's surgery. Target date:

_____

- HISTORY AND PHYSICAL
- COMPLETE METABOLIC PANEL
- COMPLETE BLOOD COUNT
- PT, PTT
- EKG

Thank you for your assistance and effort!

History and Physical

Pre-operative Diagnosis: _____

Chief Complaint/Extended History of Present Illness: _____

_____

Indications for Procedure/Surgery: _____

Proposed Procedure (consent to read): _____

_____

Anesthesia Type Requested: ☐ General ☐ MAC ☐ Regional ☐ Sedation ☐ Local

Physical Examination:

Complete for all surgeries/procedures:			
System Review	**Normal**	**Abnormal/Explain**	**Current Medications:** ☐ None ☐ See Medication List
Heart/CV			
HEENT/face			
Respiratory			
Chest/breast/axilla			
Abdomen			
Musculoskeletal			
Back			
Extremities			
GI			
GU			
Skin			
Pelvic/Rectal			
Hematology/lymphatic/ immunology			Allergies/Reactions: ☐ NKA
Neuro			
X-Ray findings			
Use drugs, alcohol, tobacco: ☐Yes ☐ No If yes, list: _____ Other relevant: ☐Yes ☐ No, If yes, list: _____ _____			Past major illnesses/injuries: ☐Yes ☐ None If yes, list: _____ _____ Age appropriate immunization status: ☐Received ☐ Not received: _____
Previous Surgeries/Hospitalizations:			Current Comorbid Conditions: ☐ None ☐ Yes/describe below

I have determined that this patient is a suitable candidate for the planned procedure at this facility. I have explained the procedure/surgery, including appropriate alternatives, benefits, side effects and risks. I have answered all the patient's/guardian's questions. The patient/guardian accepts the proposed procedural/surgical plan.

Physician Signature: _____ **Date:** _____ **Time:** _____

Complete This Section on Day of Service for History and Physical Performed within the Past 30 Days: (√ 1 box only)

☐ No change in patient condition noted after patient examination & review of H&P and admission patient history. I have determined that this patient is a suitable candidate for the planned procedure at this facility today.

☐ Change in patient condition noted after patient examination & review of H&P and admission patient history:
Describe: _____

Physician Signature: _____ **Date:** _____ **Time:** _____

History and Physical

Complete this Section for History and Physicals Performed on Day of Service:

☐ After patient examination and review of admission patient history, I have determined it is medically necessary for the patient to have surgery on the same day as referred. I have determined that this patient is a suitable candidate for the planned procedure at this facility today.

Physician Signature: _____ **Date:** _____ **Time:** _____

Physical Exam: Vital Signs: T _____ P _____ R _____ B/P _____/_____ HT _____ WT _____

Heart/CV: _____

HEENT/face: _____

Respirations: _____

Chest/breast/axilla: _____

Abdomen: _____

Musculoskeletal: _____

Back: _____

Extremities: _____

GI: _____

GU: _____

Skin: _____

Pelvic/Rectal: _____

Hematology/lymphatic/immunology: _____

Neuro: _____

Mental/psychiatry: _____

Constitutional Symptoms (fever, weight loss, etc.): _____

Lab/X-Ray Findings: _____

Pre-procedure Diagnosis: _____

Indications for Procedure/Surgery: _____

Procedure proposed: _____

Physician Name: _____ Physician Signature: _____ Date: _____

Patient Label (Optional)

Hoag Newport Center Surgicare
1441 Avocado Ave Suite 100
Newport Beach, CA 92660

STEPS YOU NEED TO DO BEFORE YOUR SURGERY:

1): CALL TO PRE-REGISTER
(949) 764-8424
as soon as possible .

2) Please fill-out the two page health history forms attached and bring it with you the day of surgery.

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Stated Height: _____ Stated Weight: _____

Primary Language: _____ Interpreter Needed? ☐ Yes ☐ No For which language? _____

Telephone #'s: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Contact Person: _____ Contact Phone Number: ( ) _____

INTERNIST/PRIMARY CARE PHYSICIAN AND VISIT INFORMATION

Internist/PCP: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

Cardiologist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

Other Specialist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

ALLERGIES AND PREVIOUS SURGERIES

Allergies Title	Reaction

Previous Surgery Details	Surgery Year	Anesthesia Used

Please indicate if you have had any of the following CARDIAC/MEDICAL procedures listed below:

Angioplasty: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No Stent Placed? ☐ Yes ☐ No

Echocardiogram: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Stress Test: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Pacemaker: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Pacemaker Brand: _____ Pacemaker Model: _____

Other Procedure: _____

CARDIOVASCULAR

☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Heart Valve Problems
☐ Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs
☐ Arrhythmias, i.e., A-Fib
☐ Coronary Artery Disease
☐ High Cholesterol
☐ Cardiomyopathy
☐ Family History of Heart Disease
☐ History of DVT/PE
☐ Carotid Artery Disease
☐ Heart Attack
☐ Hypertension

Date of Heart Attack: _____ Date of Chest Pain: _____

[1508]

Patient Name: _____

PULMONARY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ CPAP
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Tuberculosis

HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding/Clotting Disorders
- ☐ Blood Transfusions
- ☐ Leukemia/Lymphoma

GASTROINTESTINAL
- ☐ Cirrhosis
- ☐ Digestive Problems
- ☐ Gastric Reflux
- ☐ Hepatitis A, B, or C

NEUROLOGIC
- ☐ Anxiety/Depression/Mood Disorders
- ☐ Dementia
- ☐ Fainting
- ☐ Headache
- ☐ Muscle Weakness
- ☐ Neuromuscular Disorders
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke/Mini Stroke

GENITOURINARY
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Urinary Tract Infections

ENDOCRINE
- ☐ Diabetes
- ☐ Hypo/Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Recent Steroid Therapy

PAIN
- ☐ Artificial Joints, Location: _____
- ☐ Back/Neck Pain
- ☐ Chronic Pain Treatment
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

GENERAL HEALTHCARE

Do you, or have you ever had any of the following?

Cancer:

Have you had or have cancer? ☐ Yes ☐ No
Have you had radiation therapy? ☐ Yes ☐ No
Have you had chemotherapy? ☐ Yes ☐ No
Where was/is the cancer located? _____

Have you had any of the following vaccines?

Ever taken the flu vaccine? ☐ Yes ☐ No
In what date: _____

Ever taken the pneumonia vaccine? ☐ Yes ☐ No
In what year: _____

For Female Patients:

Any possibility of pregnancy? ☐ Yes ☐ No
Date of last menstrual period? _____

Tell us about your social history:

Smoking History:

Do you smoke? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
For how many years? _____
Any smoking in the past 12 months? ☐ Yes ☐ No

Alcohol History:

Do you drink alcohol? ☐ Yes ☐ No
How much alcohol do you consume and how often?
_____

Drug History:

Do you use recreational drugs? ☐ Yes ☐ No
What kind of recreational drugs do you use?
_____

Malignant Hyperthermia (MH) History:

Family history of MH? ☐ Yes ☐ No

SURGICAL INFORMATION

Do you exercise? ☐ Yes ☐ No If yes, Type: _____
Do you wear contact lenses? ☐ Yes ☐ No
Do you have caps, bridges, dentures or loose teeth? ☐ Yes ☐ No

SIGNATURES

[Patient/Parent/Conservator/Guardian] [Date] [Time] [If completed by other than patient, indicate relationship]

[Reviewed by Assessment Nurse] [Date] [Time] [Reviewed by Procedure Nurse] [Date] [Time]

[Reviewed by PACU Nurse] [Date] [Time] [Reviewed by Discharge Nurse] [Date] [Time]

HOAG HOSPITAL USE ONLY:
☐ *FAX to Pharmacy after admit physician signs*

PATIENT STATED HOME MEDICATION LIST

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information. **BRING THIS FORM WITH YOU TO HOAG.**

☐ ***Check this box if not on any home medications.***

[Signature of Patient/Responsible Person]

DESCRIBE ALLERGIES & REACTIONS:

Completed by: _____ Date/Time: _____

Source of Medication History: _____

Physician Orders on Hoag Admit: Continue or Formulary Equivalent (circle one)		Medication	Dose	Route	Freq	Reason for Taking	Dose last taken - RN to Complete	On Discharge: Stop	On Discharge: Continue (Next Dose)
Y	N	1.							
Y	N	2.							
Y	N	3.							
Y	N	4.							
Y	N	5.							
Y	N	6.							
Y	N	7.							
Y	N	8.							
Y	N	9.							
Y	N	10.							

Medication Reconciliation on Entry:

_____ [Physician Signature]

Date/Time: _____ ID#: _____

DATE TIME T/O FROM SIGNATURE/TITLE

Noted: ☐ CC/RN: _____ Date/Time: _____

☐ RN: _____ Date/Time: _____

Medication Reconciliation on Discharge:

_____ [Physician Signature]

Date/Time: _____ ID#: _____

DISCHARGE: PRINT NEW MEDICATIONS AND CHANGES TO ABOVE MEDICATIONS (PROVIDE PRESCRIPTION TO PATIENT)

Medication	Dose	Route	Freq	Reason	Special Instructions	Medication Schedule				Comments:

Original to patient on discharge. Line through stopped meds.

Discharge RN: _____

Date/Time: _____

Discharge Physician Signature: _____

Date/Time: _____ ID#: _____

DATE TIME T/O FROM SIGNATURE/TITLE

MEDICATION RECONCILIATION/ORDERS
Hoag Memorial Hospital Presbyterian

PS 7514 Rev 12/16/10

[2517]

PLACE IN FRONT OF PHYSICIAN ORDERS

Original – Patient Photocopy 1 – Chart Photocopy 2 – Primary Care Physician

Page ____ of ____ Patient Name _____