Providence HEALTH CARE

☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

SURGICAL DAYCARE ADMISSION HISTORY

NAME: _____ AGE: _____ DOB: _____

REFERRING MD: _____ FAMILY MD: _____ DATE: _____

CHIEF COMPLAINT: _____

_____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

HISTORY: _____

_____

PAST SURGERY: _____

FUNCTIONAL ENQUIRY: _____

_____

_____

_____

PHYSICAL EXAM (pertinent positive and negative findings)

B/P _____ PULSE _____ RESP _____ WEIGHT _____

HEAD & NECK _____

CHEST _____

HEART _____

ABDOMEN _____

EXTREMITIES _____

BREASTS _____

RECTAL _____

PELVIS _____

DIAGNOSIS: _____

HAEMOGLOBIN: _____ DATE: _____

OTHER TESTS: _____

PLANNED SURGICAL PROCEDURE: _____

SURGEON: _____ SIGNED: _____