Alberta Health Services

History and Physical
(Day Procedure or Treatment Post Recovery)

(For stable patients requiring a short stay in hospital post day procedures or treatments)

Last Name	
First Name	
PHN#	Birthdate *(dd-Mon-yyyy)*

May also submit a dictated copy. ***(Must be current within past 12 months)***

Diagnosis

All known Allergies & Sensitivities ☐ None

Trigger Reaction

☐ Continued on attached page

Reason for Referral/Procedure

Past Illness and Operations

Pertinent Physical Examination

Ht _____ Wt _____

HR _____ RR _____

BP _____

Previous Anaesthetic History

Neck and Head ☐ No significant abnormality

Cardiac ☐ None

☐ Hypertension ☐ CHF

☐ MI ☐ Cardiac Arrhythmia

☐ Angina ☐ Anticoagulants

Cardiac ☐ No significant abnormality

Respiratory ☐ None

☐ Asthma

☐ COPD

☐ Smoker Amount _____

☐ Sleep Apnea Treatment _____

Respiratory ☐ No significant abnormality

Endocrine ☐ None

☐ Diabetes

☐ Diet Controlled ☐ Thyroid

☐ Insulin Controlled

☐ Oral Hypoglycemics

Abdomen ☐ No significant abnormality

GI/GU ☐ None

☐ Peptic Ulcer ☐ Renal Impairment

☐ GERD ☐ Malabsorption Disorder

GI/GU ☐ No significant abnormality

LMP if known _____

MSK/ADL/Mobility/Function ☐ None

MSK ☐ No significant abnormality

☐ Mobility/Functional Impairments

Other ☐ No significant abnormality

☐ Recreational Drugs/Alcohol _____

Recent Relevant Labs, ECG, DI

Medications ☐ None ☐ See Attached

Drug Dosage Frequency

☐ Continued on attached page

Completed by *(name)* ☐ Family Physician ☐ Consult Service	Signature	Date Completed *(yyyy-Mon-dd)*
Date Reviewed (by Consult Service/Interventionalist)	Signature	