ALBERTA SURGICAL CENTRE
PHYSICIAN HISTORY AND PHYSICAL

Suite 202 West Tower, 14310 – 111 Avenue, Edmonton, AB T5M 3Z7 Phone: 780-488-2724 Fax: 780-488-2774
Completed form should be faxed to surgeon office FAX# 780-428-1032

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City: _____ Prov: ____

Postal Code: _____ Phone Number: _____

ULI/PHN: _____ Gender: _____ Surgeon: _____

Chief complaint/Proposed surgery

Height _____ **in/cm** **Weight** _____ **lbs/kilo**

BMI _____ **BP** _____ **Pulse** _____**Resp** _____

Past Illness and operations

Pertinent Physical Examination

Cardiac

☐ None

☐ ECG ordered for anyone over 55 years of age.
☐ Hypertension
☐ MI
☐ Angina
☐ CHF
☐ Cardiac Arrhythmias

Neck and Head ☐ No significant abnormality

Heart ☐ No significant abnormality

Respiratory ☐ None

☐ Asthma
☐ COPD

Lungs ☐ No significant abnormality

Endocrine ☐ None

☐ Diabetes
  ☐ Diet Controlled
  ☐ Oral Hypoglycemics
  ☐ Insulin controlled.
☐ Thyroid

Abdomen ☐ No significant abnormality

Musculoskeletal ☐ No significant abnormality

GI/GU ☐ None

☐ Peptic ulcer
☐ Renal failure
☐ Malabsorption disorder
☐ GERD

Pelvic/GU ☐ No significant abnormality

LMP

Medications ☐ None

Allergies ☐ None

☐

General Condition and diagnosis

HISTORY: ☐ **Surgeon** ☐ **Family Physician** ☐ **Anesthetist** **Date Completed:** _____

Physician (print name) _____ Physician signature _____

Physician Phone Number: _____ Physician Fax Number: _____

Routine Preoperative Investigation: Follow Alberta Health Services Pre-Admission Guidelines