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Radiology Associates L.L.C.

Pre-Procedure History and Physical

Patient Name: _____ DOB: _____

Diagnosis/History of Present Illness: _____

_____

_____

_____

Past Medical History: _____

_____

_____

_____

_____

_____

_____

Prior Surgery: _____

_____

_____

_____

_____

_____

Problems with Surgery/Anesthesia: ☐ None

_____

Current Medications and Dosages (include Herbals, Over the Counter):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: ☐ None Known

_____

System Review: (Check when Reviewed; Comment if Positive)

☐ Head/Neck _____	☐ Integumentary _____
☐ Cardiac _____	☐ Neurological _____
☐ Pulmonary _____	☐ Psychiatric _____
☐ Gastrointestinal _____	☐ Endocrine _____
☐ Genitourinary _____	☐ Musculoskeletal _____
☐ Hematologic _____	☐ Immunology _____

Pre-Procedure History and Physical

Cardiovascular History: ☐ None (Check and Comment below if yes)

☐ Hypertension _____ ☐ Angina _____
☐ MI (Dates) _____ ☐ CABG _____
☐ CHF _____ ☐ Valve Disease _____
☐ Angioplasty (Dates) _____ ☐ Arrhythmia _____

Pulmonary History: ☐ None (Check and Comment below if yes)

☐ COPD _____ ☐ Sleep Apnea _____
☐ CPAP _____ ☐ Asthma _____
☐ Steroids _____ ☐ Other _____

Social History:

☐ Smoking Packs/Years _____ Current Use? ☐ Yes ☐ No
☐ ETOH: _____ ☐ H/O Substance Abuse

Family History: ☐ Non-contributory

Physical Exam:

BP: **Pulse:** **RR:** **Wt:** **Ht:**

(Check when reviewed: describe if abnormal)

☐ General _____
☐ HEENT _____
☐ Pulmonary _____
☐ Cardiac _____
☐ Gastrointestinal _____
☐ Musculoskeletal _____
☐ Skin _____
☐ Neurological _____
☐ Psychiatric _____
☐ Other _____

Labs: _____

Imaging Studies: _____

Impression: _____

Plan: _____

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