ORLANDO REGIONAL HEALTHCARE
1414 Kuhl Avenue • Orlando, Florida 32806-2093

OUTPATIENT SHORT STAY HISTORY AND PHYSICAL RECORD

Please fax back to (321) 422-5692 when completed.

Patient's Name:

LINE UP PATIENT I.D. LABEL HERE

HISTORY (Present Illness)	PHYSICAL EXAM
	VITAL SIGNS:
	MENTAL ASSESSMENT: Awake & alert ☐ Yes ☐ No: Other
	HEENT: Within normal limits: ☐ Yes ☐ No: Other
PAST HISTORY If "Yes" explain	HEART: Regular: ☐ Yes ☐ No: Other
Medical ☐ None ☐ Yes:	
Surgical ☐ None ☐ Yes:	CHEST: Clear to ausculation: ☐ Yes ☐ No: Other
Previous Anesthesia Difficulties ☐ None ☐ Yes:	ABDOMEN: Soft & non-tender: ☐ Yes ☐ No: Other
Medications ☐ None ☐ Yes:	NEUROMUSCULAR: Grossly Intact ☐ Yes ☐ No: Other
Allergies Food ☐ None ☐ Yes: Drugs ☐ None ☐ Yes:	EXTREMITIES: Other
Bleeding Tendencies	OTHER:
Family History	
Social History	

REVIEW OF SYSTEMS: All systems within normal ranges (explain any boxes that are checked)

CV:	☐ BP	☐ Chest Pain	☐ Irregular HR
ENDO:	☐ Diabetes	☐ Thyroid	☐ Heat or cold intolerance
G.I.:	☐ Reflux	☐ Heartburn	☐ Hepatitis/Jaundice
G.U.:	☐ Burning	☐ Infections	☐ Pain/Blood on urination

HEMATOLOGICAL: ☐ Abnormal ☐ Bleeding ☐ Bruising

MUSCULOSKELTAL: ☐ Stiffness ☐ Muscle ☐ Arthritis ☐ Joint

NEUROLOGICAL: ☐ Fainting ☐ Seizures ☐ numbness ☐ Weakness

PULMONARY: Cough with: ☐ Sputum ☐ Blood ☐ Asthma ☐ Pneumonia ☐ T.B. ☐ Bronchitis

(Explanation:) ______

☐ Additional notes on back

IMPRESSION:

PLAN:

MD's Signature:

______, M.D. I.D. #: ______ Date/Time: ______