

Please include list of medications and fax back when completed to **416-619-5539**



Patient Identification

**Pre-operative History and Physical Examination**

**Note:** to be completed by patient's primary care physician.

Patient Name: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Surgeon(s): **Dr. E. Margolin**

Cataract extraction with IOL insertion into the \_\_\_\_\_ eye

Proposed surgery: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_  
name and dosage

Past medical and surgical history: \_\_\_\_\_

**Functional Inquiry:**

**Normal    If Abnormal, describe**

- Neurological
- Cardiovascular  for significant heart disease, please attach recent EKG
- Respiratory
- Gastrointestinal
- Genitourinary
- Endocrine
- Hematological
- Musculoskeletal

**Physical Examination:**

Heart Rate:		Respiratory Rate:		Blood Pressure:		Height (cm):		Weight (kg):	
System	Normal	Abnormal	System	Normal	Abnormal	System	Normal	Abnormal	
General	<input type="checkbox"/>	<input type="checkbox"/>	Head, Eyes, Ears, Nose, and Throat	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Skin and Hair	<input type="checkbox"/>	<input type="checkbox"/>				
Heart	<input type="checkbox"/>	<input type="checkbox"/>							

Describe Abnormalities: \_\_\_\_\_

Impression: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ PRINT Name: \_\_\_\_\_ MD  
Month/Day/Year                      HH:MM

MD Phone: \_\_\_\_\_ MD Fax: \_\_\_\_\_ Signature: \_\_\_\_\_ MD