thesurgicalsuites
First Insurance Building
1100 Ward Avenue, Suite 1001/1010
Honolulu, HI 96814
PH: (808) 531-0127 FAX: (808)531-0455

Minimum of 3 days prior to scheduled procedure, please complete this H&P form and fax to The Surgical Suites at **531-0455 AND**

☐ Dr. Tyrie Jenkins 591-9909 ☐ Dr. Carlos Omphroy 625-1221
☑ Dr. Alan Faulkner 599-4818 ☐ Dr. Jon Portis 523-0466
☐ Dr. Ming Chen 523-0466

HISTORY AND PHYSICAL FORM

PATIENT NAME:_____ **DOB:**_____

TYPE OF PROCEDURE:_____ ☐ **RIGHT** ☐ **LEFT**

CHIEF COMPLAINT AND PRESENT ILLNESS: _____

INDICTION FOR PROCEDURE: Poor vision ----- tearing ---- glare

DIFFICULTY: Reading Driving Activities Household

Please complete Lab work / EKG as medically indicated

MEDICAL / SURGICAL HISTORY: **(REQUIRED)** _____

_____

ALLERGIES: (**REQUIRED**) _____

MEDICATIONS: (**REQUIRED**) _____

HT:_____ WT:_____ BP: _____ PULSE: _____ RESP: _____

HEENT: _____

Heart: _____

Lungs: _____

Abdomen: _____

Extremities: _____

Impression: _____

Patient is cleared for AMBULATORY surgery **YES / NO**

Is the patient on any medication or treatment that you wish to continue? _____

DATE: _____ Signature: _____ M.D.

Print Name: _____ M.D.

Phone #: (808) _____

Addendum: _____

_____