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 545-7236
☐ Dr. Ming Chen 523-0466 ☐ Dr. Jeffrey Peterson 591-9909

HISTORY AND PHYSICAL FORM INITIAL

PATIENT NAME: _____ **DOB:** _____

TYPE OF PROCEDURE: CATARACT SURGERY **☐ 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)** _____

_____ ☐ See Attached

ALLERGIES: (REQUIRED) _____ ☐ See Attached

MEDICATIONS: (REQUIRED) _____ ☐ See Attached

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

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: _____

_____