

## HISTORY AND PHYSICAL FORM

Surgery Date: Surgeon: Alan R. Faulkner, MD Neda Nikpoor, MD  Type of Surgery:
Type of Surgery:  Refractive Lens Exchange Cataract Surgery Glare Pterygium Surgery Discomfort Blepharoplasty Other:  COMPLETED FORM MUST HAVE EXAM DATE WITHIN 30 DAYS OF SURGERY Surgery will be performed under topical anesthesia & MAC Lab work is not required for local, standby, or topical cases; EKG as medically indicated.  Exam Date: BP: Pulse: Resp: HT: WT: Allergies: Medical / Surgical History: Medications: HEENT:
□ Refractive Lens Exchange □ Poor vision   □ Cataract Surgery □ Obstructed vision   □ Visian ICL Surgery □ Discomfort   □ Blepharoplasty □ Desire to be free of glasses   □ Other: □ Other:    • COMPLETED FORM MUST HAVE EXAM DATE WITHIN 30 DAYS OF SURGERY  • Surgery will be performed under topical anesthesia & MAC  • Lab work is not required for local, standby, or topical cases; EKG as medically indicated.  Exam Date:  BP: / Pulse: Resp: HT: WT: Allergies:  Medical / Surgical History: Medications: HEENT: HEENT: HEENT: Allergies: HEENT: HEENT: HEENT: HEENT: HERDT: HERDT: HERDT: HERDT: HERDT: HERDT: HERDT: HERDT: HENDT: HERDT:
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□ Pterygium Surgery □ Usian ICL Surgery □ Discomfort □ Blepharoplasty □ Other: □ Other: □ COMPLETED FORM MUST HAVE EXAM DATE WITHIN 30 DAYS OF SURGERY • Surgery will be performed under topical anesthesia & MAC • Lab work is not required for local, standby, or topical cases; EKG as medically indicated.  Exam Date: □ Pulse: □ Pulse: □ Resp: □ HT: □ WT: □ Medical / Surgical History: □ Medications: □ HEENT: □ Usian ICL Surgery □ Discomfort □ Discomfort □ Discomfort □ Desire to be free of glasses □ Other: □ Other: □ Other: □ HT: □ WT: □ WT: □ Medications: □ HEENT:
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BP: / Pulse: Resp: HT: WT:         Allergies:         Medical / Surgical History:         Medications:         HEENT:
Allergies:
Medical / Surgical History:
Medications:
HEENT:
Heart:
Lungs:
Abdomen:
Extremities:
Impression:
>> Is the patient cleared for AMBULATORY surgery? (circle one) YES / NO
Is the patient on any medication or treatment that should not be stopped for surgery?
Additional comments:
Doctor's Signature: Date:
Print Doctor's Name: Doctor's office phone #:

\*\*PLEASE FAX THE COMPLETED FORM TO ALOHA LASER VISION AT 808-599-4818\*\*