



CEDARS-SINAI MEDICAL CENTER

AMBULATORY SURGERY / SHORT STAY HISTORY & PHYSICAL

(To be used only if planned admission is less than 48 hrs.)

PATIENT I.D.

DATE:	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	OCCUPATION
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PRESENT ILLNESS (Onset-Complaint):

RELEVANT FAMILY HISTORY:

ALLERGIES:

MEDICATIONS:

IMMUNIZATIONS:

PAST MEDICAL HISTORY/ REVIEW OF SYSTEMS:

PHYSICAL EXAMINATION: VITAL SIGNS: BP _____ TEMP _____ PULSE _____ RESP. _____

DX/PLAN OF CARE:

		RESIDENT SIGNATURE:
DATE:	TIME:	PHYSICIAN SIGNATURE: M.D.

