SURGISITE BOSTON
West Suburban Eye Surgery Center, LLC
1440 Main St., Waltham, MA 02451

PATIENT HISTORY AND PHYSICAL
Must be completed within **30 days** of surgical date

Please fax to Putnoi Eye Care at 781-235-2444
* 10 TO 30 DAYS PRIOR TO SURGERY *

Patient Name: _____Date of Surgery: _____

Operation: **Cataract Extraction - RIGHT / LEFT eye** Age: _____

Surgeon: **Dr. Eric Putnoi** Sex: _____

Diagnosis: **Visually Significant Cataract - RIGHT / LEFT eye**

Vital Signs: B/P _____ P _____ R_____ Temp _____

HISTORY
Past History/ Surgeries:

Family History:

Medications & **Dosages**: Allergies:

PHYSICAL EXAM
Eyes: Abdomen:
ENT:
Respiratory Function: Mental Status:

Cardio Vascular:

ALL PATIENTS WITH AN ICD NEED AN ICD FUNCTION REPORT AND NOTE FROM CARDIOLOGIST. BLOOD WORK REQUIRED ONLY AT PCP DISCRETION.

Impressions:

After examining the patient and reviewing the preoperative data, I find this patient to be medically stable for the proposed surgery.

_____ _____
Doctor Date