3660 Waialae Avenue, Suite 304, Honolulu, Hawaii 96816
Telephone (808) 735-1935 • Facsimile (808) 735-6875
www.eyesighthawaii.com

Patient Name ____________________________________ Surgery Date ______________________
Pre-Operative Diagnosis: ___________________________________, ____________________EYE
Planned Procedure: ____, ____________________EYE
Planned Anesthesia: LOCAL/STANDBY

____

Allergies: ____
Current Medications ____
____
____

Previous Surgery History ____

Untoward reactions to surgery by patient or to anesthesia by patient or family ________________
____

Review of Systems:

HEENT ____________________________
Cardiac Murmur or Disease ____________
Respiratory Disease __________________
Gastrointestinal Disease _______________
Genito-Urinary Disease ________________
Neurological Disease __________________
Bleeding Disorder _____________________

Physical Examination:

BP: P: R: WT: HT:
General Appearance _____________________
Heart __________________________________
Lungs _________________________________
Abdomen _______________________________
Gento-Urinary __________________________
Neurological ____________________________

Impression: ____
____
____
____
____

Physician's Name ____

Physician's Signature ____ Date ________________
Anesthesiologist: NO INTERVAL CHANGES ______ Date _________Signature______________

Please fax this completed sheet to 735-6875, from outer islands 808-735-6875 by ___________.

Thank you,
John Olkowski, MD