

Pre-op History and Physical Form

To Be Completed By PHYSICIAN - PA or Nurse Practitioner Requires Physician Signature

Patient Name: _____ DOB: _____ Date: _____

Diagnosis: _____ Proposed Surgical Procedure: _____

Surgeon: _____ Date of Surgery: _____

Medical History/ Review of Systems - Check Box if applicable

- | | | | |
|--|---|---|--|
| <u>Cardiovascular</u> <input type="checkbox"/> none | <u>Pulmonary</u> <input type="checkbox"/> none | <u>Neuromuscular</u> <input type="checkbox"/> none | <u>GI Endocrine</u> <input type="checkbox"/> none |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> TIA or stroke | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Angina/chest pain | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Seizures | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> MI / CAD | <input type="checkbox"/> Smoking History | <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Hepatitis Type ____ |
| <input type="checkbox"/> CHF | <input type="checkbox"/> SOB | <input type="checkbox"/> Dementia | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Arrythmia/ palpitations | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Pacemaker/ AICD | <input type="checkbox"/> CPAP | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Recent Steroid Use |
| <input type="checkbox"/> Valvular Disease | <input type="checkbox"/> Cough | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> CABG/ Cardiac Surgery | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Neuromuscular Disease | Diabetes <u>I</u> <u>II</u> |
| <input type="checkbox"/> Coronary Stent | <input type="checkbox"/> PND/ Orthopnea | <input type="checkbox"/> Syncope | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Poor Exercise Tolerance | <input type="checkbox"/> URI | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> PVD | <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Other _____ | | | |

- | | | | |
|---|--|---|--|
| <u>Hematologic</u> <input type="checkbox"/> none | <u>GYN/GU Renal</u> <input type="checkbox"/> none | <u>Anesthesia Airway</u> <input type="checkbox"/> none | <u>Pediatrics</u> <input type="checkbox"/> normal |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Family Hx Anesthesia problems | <input type="checkbox"/> Recent URI/ Illness |
| <input type="checkbox"/> Sickle Cell Disease / Trait | <input type="checkbox"/> LMP _____ | <input type="checkbox"/> Previous Anesthesia Complications | <input type="checkbox"/> Prematurity |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Kidney Disease | | <input type="checkbox"/> Congenital Anomaly |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> UTI | | <input type="checkbox"/> Apnea |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | | | |

Comments on Positives or Symptoms/Conditions Not Listed: _____

Allergies

Current Medications

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Past Surgical History

Date	Surgery	Hospital Name	Complications

Social History: Smoking _____ Alcohol _____ Drugs _____

Family History: non-contributory _____

Patient Name: _____

Pre-operative Physical Examination Form – PAGE 2

PHYSICAL EXAM

Sex	Race	Age	Height	Weight	BP	Pulse	Resp	Temp

General Appearance _____

HEENT PERRLA EOMI No Lymphadenopathy No JVD O/P MNL Thyroid WNL WNL
Abnormal: _____

Cardiovascular RRR S1S2 S3 S4
Abnormal: _____

Pulmonary Lungs CTA B/L
Abnormal: _____

GI Abd Benign- Normoactive BS No Hepatosplenomegaly
Abnormal: _____

Extremities No Clubbing No Cyanosis No Edema
Abnormal: _____

Musculoskeletal NML Muscle Tone NML Strength
Abnormal: _____

Neurological CN II-XII DTR intact and equal bilaterally NML Mental Status
Abnormal: _____

Genitalia/Rectum Deferred No masses Heme negative
Abnormal: _____

Assessment: medical conditions optimized, further testing not recommend, patient may proceed directly to surgery

Further evaluation needed as follows: _____

Comments: _____

MD/Name (Print) _____ Date _____

Physician Signature _____ Phone Number (____) _____
 Private Line (____) _____

PLEASE FAX FORMS IMMEDIATELY UPON COMPLETION TO 301-309-6863. FAILURE TO RECEIVE FORMS AT LEAST ONE WEEK PRIOR TO SURGICAL DATE MAY RESULT IN CANCELLATION OF THE PROCEDURE. THANK YOU.