

Preoperative History & Physical

Please fax to 952-456-7399

Patient Name: _____ Date of Birth: _____

Surgeon: _____ Date of Surgery: _____

Date of Exam: _____

PREOP DIAGNOSIS / REASON FOR SURGERY: _____

SURGERY / PROCEDURES INDICATED: _____

HISTORY OF PRESENT ILLNESS: _____

Has a member of your Family or a Partner (now or in the past) intimidated, hurt, manipulated or controlled you in any way?

☐ Yes ☐ No Referral needed: ☐ Yes ☐ No

PAST HISTORY:

Surgical (including any anesthetic problems): _____

Medical: ☐ CAD ☐ HTN ☐ Valvular heart disease ☐ Dysrhythmia ☐ CHF ☐ Pulmonary disease
☐ Other: _____

MEDICATIONS (include herbals and vitamins):

Aspirin / NSAID use in last 10 days: ☐ Yes ☐ No Steroid use in last 10 days: ☐ Yes ☐ No

Plavix use in last 7 days: ☐ Yes ☐ No

Medications	Dose	Frequency	Medications	Dose	Frequency

ALLERGIES: _____ ☐ Latex ☐ Tape **INTOLERANCES:** _____

SOCIAL HISTORY: (☐ tobacco, ☐ alcohol, or ☐ drug use): _____

Health Care Directive: ☐ Yes ☐ No

Nutrition Status: _____

Learning Barriers: _____

FAMILY HISTORY: _____

FH of anesthesia reactions ☐ Yes ☐ No (if Yes, comment): _____ FH of bleeding disorder ☐ Yes ☐ No

REVIEW OF SYSTEMS (any history or symptoms of the following):

Yes	No	Comments if Yes	Yes	No	Comments if Yes
<input type="checkbox"/>	<input type="checkbox"/>	General Appearance: _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Endocrine: _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin: _____	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular: _____
<input type="checkbox"/>	<input type="checkbox"/>	Head: _____	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory: _____
<input type="checkbox"/>	<input type="checkbox"/>	Eyes: _____	<input type="checkbox"/>	<input type="checkbox"/>	GI/Hepatitis: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ears: _____	<input type="checkbox"/>	<input type="checkbox"/>	Urinary: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nose: _____	<input type="checkbox"/>	<input type="checkbox"/>	Neurological: _____
<input type="checkbox"/>	<input type="checkbox"/>	Mouth and Throat: _____	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic: _____
<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease: _____	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal: _____
<input type="checkbox"/>	<input type="checkbox"/>	Psychological: _____	<input type="checkbox"/>	<input type="checkbox"/>	Genito-reproductive: _____

CROSSTOWN SURGERY CENTER

Phone: (952) 456-7300

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Patient Name: _____

PHYSICAL EXAM:

Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____
Pulse: _____ Respirations: _____ LMP: _____ Women of child bearing age need a pregnancy test:
Results _____

	<u>Normal</u>	<u>Abnormal - describe</u>		<u>Normal</u>	<u>Abnormal - describe</u>
General Appearance	<input type="checkbox"/>	_____	Heart	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	_____	Abdomen	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	_____	Vaginal	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	_____	Rectal	<input type="checkbox"/>	_____
Nose	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	_____
Mouth and Throat	<input type="checkbox"/>	_____	Lymphatics	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	_____	Blood Vessels	<input type="checkbox"/>	_____
Thorax	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	_____
Breasts	<input type="checkbox"/>	_____	Other Findings/Diagnosis:	_____	_____
Lungs	<input type="checkbox"/>	_____			

LAB / RADIOLOGY RESULTS:

Hgb: _____ PLT: _____ INR: _____ BUN/Creat: _____

CXR: _____ (New or unstable cardiopulmonary disease)

Electrolytes: K + _____ (Digoxin or diuretic use, or renal disease)

If Diabetic, Glucose: _____

EKG: _____ (Enclosed copy) (Consider age guidelines: patients ≥ 60 or patients with hypertension, diabetes, peripheral vascular disease, chest pain, CAD if not done in last 6 months)

ECHO: _____ Stress Testing: _____

PFT: FEV₁ _____ FVC _____

Other Test Results: _____

IMPRESSION / ACTIVE PROBLEMS:

☐ CAD: Severity/functional status: _____ ☐ Stable ☐ Needs preop evaluation
Most recent evaluation/intervention: _____

☐ HTN: ☐ Well controlled ☐ Other _____

☐ Valvular heart disease (or undefined murmur): Lesions/severity _____ ☐ Stable ☐ Needs preop evaluation
Last Echo: _____

☐ Dysrhythmia ☐ Atrial Fibrillation/Flutter ☐ Rate controlled ☐ Other: _____
☐ History of ventricular dysrhythmia _____

☐ CHF (or history of): Etiology: _____ ☐ Well compensated ☐ Other: _____
Last Echo: _____

☐ Pulmonary disease: ☐ COPD: _____ ☐ Restrictive ☐ Stable ☐ Other: _____
Last PFT: _____

☐ Sleep Apnea History of: _____

Other pertinent diagnoses: _____

PLAN: ☐ Patient's active problems diagnostically and therapeutically optimized for planned procedure.☐ Other _____

Provider Signature: _____ Date: _____ Time: _____

Print Provider Name: _____

Clinic Name and Number: _____