EAGAN
ORTHOPEDIC
SURGERY CENTER

Preoperative History & Physical

Please fax to 952-456-7101

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
☐	☐	General Appearance:		☐	☐	Diabetes/Endocrine:	
☐	☐	Skin:		☐	☐	Cardiovascular:	
☐	☐	Head:		☐	☐	Respiratory:	
☐	☐	Eyes:		☐	☐	GI/Hepatitis:	
☐	☐	Ears:		☐	☐	Urinary:	
☐	☐	Nose:		☐	☐	Neurological:	
☐	☐	Mouth and Throat:		☐	☐	Hematologic:	
☐	☐	Infectious Disease:		☐	☐	Musculoskeletal:	
☐	☐	Psychological:		☐	☐	Genito-reproductive:	

EAGAN ORTHOPEDIC SURGERY CENTER
Phone: (952) 456-7100

Preoperative History & Physical

Please fax to 952-456-7101

Patient Name:_____

PHYSICAL EXAM:

Height:_____ Weight:_____ BMI:_____ Blood Pressure:_____

Pulse:_____ Respirations:_____ LMP:_____ Women of child bearing age need a pregnancy test:

Results_____.

	Normal	Abnormal - describe		Normal	Abnormal - describe
General Appearance	☐	_____	Heart	☐	_____
Skin	☐	_____	Abdomen	☐	_____
Head	☐	_____	Genitourinary	☐	_____
Eyes	☐	_____	Vaginal	☐	_____
Ears	☐	_____	Rectal	☐	_____
Nose	☐	_____	Musculoskeletal	☐	_____
Mouth and Throat	☐	_____	Lymphatics	☐	_____
Neck	☐	_____	Blood Vessels	☐	_____
Thorax	☐	_____	Neurological	☐	_____
Breasts	☐	_____	Other Findings/Diagnosis:		_____
Lungs	☐	_____			

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: FEV_1_____ 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 evaluatior
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:_____