

**PRE-OPERATIVE
 HISTORY AND PHYSICAL FORM**

(PATIENT IDENTIFICATION)

TO BE COMPLETED BY PATIENT, NURSE OR PHYSICIAN

I. HISTORY (PLACE ADDITIONAL COMMENTS ON BACK)

PATIENT INFORMATION

NAME: _____ AGE: _____ BIRTH DATE _____ SEX M F
 HEIGHT: _____ WEIGHT: _____ ALLERGIES: _____
 ANY MEDICATION REACTION: YES NO _____

CURRENT MEDICATIONS AND DOSAGE: _____

	NEG.	POS.	POS. (EXPLAIN)		NEG.	POS.	POS. (EXPLAIN)
RESPIRATORY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	_____	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
SMOKER	<input type="checkbox"/>	<input type="checkbox"/>	_____	RENAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	NEUROLOGIC DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	_____	INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	_____	STEROID USE IN PAST 2 MO.	<input type="checkbox"/>	<input type="checkbox"/>	_____
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALCOHOL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____	ILLICIT DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	_____
EPILEPSY/SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	_____	POST OP NAUSEA HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____	HISTORY OR FAMILY HISTORY			_____
GASTRO INTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	_____	OF ANESTHESIA PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____
COMMENTS: _____				FERTILE FEMALE			
_____				STERILIZED	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____				<input type="checkbox"/> ABOVE HX INFORMATION ENTIRELY NEGATIVE			

TO BE COMPLETED BY PHYSICIAN PERFORMING PROCEDURE

SURGEON'S NAME: _____ DATE OF SURGERY: _____
 REVIEW RISKS AND BENEFITS OF SURGICAL PROCEDURE: YES NO _____
 CHIEF COMPLAINT: _____
 INDICATIONS/SYMPTOMS/PRE OP DX SURGICAL PROCEDURES: _____
 SURGICAL PROCEDURE: _____
 ANESTHESIA TYPE: GEN M.A.C. REGIONAL-SPINAL, EPIDURAL, BIER BLOCK, AXILLARY, CHOICE
 IV SED LOCAL ANESTHESIA THERAPEUTIC BLOCK

II. PHYSICAL	NOT EXAMINED			ABNORMAL	NOT EXAMINED			ABNORMAL	
	NEG	NEG	ABNORMAL		NEG	NEG	ABNORMAL		
MENTAL STATUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	OTHER _____				
					PELVIC EXAM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

MD Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN ON THE DAY OF THE PROCEDURE

Reviewed: _____ M.D. Signature _____ Date _____