

Patient Name: _____
Date of Examination _____

AGE _____ M / F
Date of Surgery: _____

Medical History:

Allergies: NKDA _____

Medications: both prescription and over-the-counter (including doses):

Alcohol _____ Drinks per _____ () None
Street drugs () Yes () No () Type: _____
Blood/Fluid Precautions: () Yes () No

Past Surgical History/ Type of Anesthesia/ Complications:

1. _____
2. _____
3. _____
4. _____

ROS: HEENT:

Sleep apnea or compromised airway () Yes () No CPAP: () Yes () No
O2? () Yes () No

Cardiovascular:

Walk 1-2 blocks:	() Yes	() No	
Climb flight of stairs:	() Yes	() No	
Prior MI	() Yes	() No	
Palpitations	() Yes	() No	
Prior CHF	() Yes	() No	If Yes, when? _____
Angina	() Yes	() No	
Angioplasty	() Yes	() No	If Yes, when? _____
CABG	() Yes	() No	If Yes, when? _____
Arrythmia	() Yes	() No	If Yes, when? _____
PVD	() Yes	() No	
Able to lie flat	() Yes	() No	Number of pillows: _____
Pacemaker	() Yes	() No	Last check date [] _____
Exercise Tolerance:	_____		

Respiratory:

COPD	() Yes	() No	
Chronic cough	() Yes	() No	
Productive	() Yes	() No	
Smoker	() Yes	() No	Pack-years: _____
Other:	_____		

Gastrointestinal:

GERD	() Yes	() No	Controlled () Yes () No
Elevations of LFT's	() Acute	() Chronic	
Hepatitis	() Yes	() No	Type _____
Other:	_____		

Renal:

Dialysis	() Yes	() No	Number of years _____
CRI	() Yes	() No	

Patient Name _____

Gyne:

Possibility of untreated pregnancy () Yes () No
Last menstrual period: _____

Endocrine:

Diabetes () Yes () No
Graves () Yes () No
Hypothyroid () Yes () No

CNS:

CVA () Yes () No When? _____ Residual? _____
Seizures () Yes () No Date of last seizure _____

Family History:

Family history of anesthetic complications () Yes () No
Other: _____

Physical Examination: BP _____ Pulse _____ RR _____ T _____ Wgt _____ Ht: _____

HEENT:

Lungs:

Heart: Rate/minute: _____ Rhythm: _____
Murmurs: () Yes () No If Yes, please attach last echo

Abdomen:

Extremities:

Neurological:

Laboratory: EKG _____ Any change? _____ Date: _____
ECHO _____ Ejection Fraction _____ Date: _____

Stress Test _____ Date: _____
CBC: _____ Lytes: _____

LFTs: _____ TSH: _____

Patient's medical condition is optimal for planned procedure: () Yes () No

Recommendations:

Signature of examining physician: _____ **Date of exam:** _____

Printed Name: _____ **Telephone :** _____

H&Ps done by nurse practitioners and/or physician assistants need MD co-signature. Thank you.