

Name: _____ Date: _____

SOCIAL

Age: _____ Sex: M F Married: Y N Occupation: _____
 Responsible Adult Available to Assist During Recovery Period Y N Relationship: _____

HABITS

Smoke: Y N Amount: _____ Coffee/Tea/Cola: Y N Amount: _____
 Alcohol: Y N Amount: _____ Daily Exercise: Y N Amount: _____

MEDICATIONS: List dose or number of pills per day
 Prescription Drugs

Non Prescription (Vitamins; Herbs)

Regular Aspirin Use: Y N Dosage & frequency: _____
 NSA (Advil, Motrin, Ibuprofen): Y N Dosage & frequency: _____
 Cortisone Injections Past Year: Y N Date(s) and injection location: _____

Drug Allergy: Y N List drug(s) and type of reaction: _____

Latex Allergy: Y N Tape Allergy Y N

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y <input type="checkbox"/> N <input type="checkbox"/>	Coronary Surgery: Y <input type="checkbox"/> N <input type="checkbox"/>	Kidney Disease: Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting: Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes: Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis: Y <input type="checkbox"/> N <input type="checkbox"/>
Anesthetic Problems: Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack: Y <input type="checkbox"/> N <input type="checkbox"/>	Other Serious Illness: Y <input type="checkbox"/> N <input type="checkbox"/>
Cancer: Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension: Y <input type="checkbox"/> N <input type="checkbox"/>	

Please describe questions with a "Yes" answer: _____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding: Y <input type="checkbox"/> N <input type="checkbox"/>	Asthma: Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension: Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting: Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes: Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep Apnea: Y <input type="checkbox"/> N <input type="checkbox"/>
Acid Regurgitation: Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting Spell: Y <input type="checkbox"/> N <input type="checkbox"/>	Snoring: Y <input type="checkbox"/> N <input type="checkbox"/>
Anemia: Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack: Y <input type="checkbox"/> N <input type="checkbox"/>	Weight Change past 12 Mo.: Y <input type="checkbox"/> N <input type="checkbox"/>
Angina: Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis: Y <input type="checkbox"/> N <input type="checkbox"/>	Other Serious Illness: Y <input type="checkbox"/> N <input type="checkbox"/>

Please describe questions with a "Yes" answer: _____

Have you ever received a transfusion? Y N If yes, what year? _____

Have you been tested for HIV? Y N If yes, what year _____ Test results: positive negative

Do you wear: Contact lenses: Y N Eye glasses: Y N Hearing aid: Y N Dentures: Y N

Previous Surgery, year and type of procedure: _____

Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

- Local anesthesia - (complications/reactions): _____
- General anesthesia -(complications/reactions): _____
- Spinal / Epidural - (complications/reactions): _____

Date last seen by Primary Care Physician: _____

Primary Care Physician (name) _____ (telephone) (_____) _____
 (address) _____

WOMEN PATIENTS ONLY:

Number of pregnancies _____ Number of children _____ Last menstrual period _____ Did you breast feed? Yes No

FIG. 1. First page of preoperative history and physical examination form.

Name: _____ **MRN:** _____ **Date:** _____

Completed by Physician

REVIEW OF SYSTEMS

Loose Dental Devices:	Y <input type="checkbox"/> N <input type="checkbox"/>	Chest Pain:	Y <input type="checkbox"/> N <input type="checkbox"/>
Neck Mobility Problem:	Y <input type="checkbox"/> N <input type="checkbox"/>	Irregular Heart Beat:	Y <input type="checkbox"/> N <input type="checkbox"/>
Short Neck:	Y <input type="checkbox"/> N <input type="checkbox"/>	Vomiting:	Y <input type="checkbox"/> N <input type="checkbox"/>
Cough:	Y <input type="checkbox"/> N <input type="checkbox"/>	Difficult Voiding:	Y <input type="checkbox"/> N <input type="checkbox"/>
Shortness of Breath:	Y <input type="checkbox"/> N <input type="checkbox"/>	Seizure:	Y <input type="checkbox"/> N <input type="checkbox"/>
Recent Upper Respiratory Infection:	Y <input type="checkbox"/> N <input type="checkbox"/>	Current Pregnancy:	Y <input type="checkbox"/> N <input type="checkbox"/>
Normal Menstrual Period:	Y <input type="checkbox"/> N <input type="checkbox"/>	Black Out:	Y <input type="checkbox"/> N <input type="checkbox"/>
Stroke:	Y <input type="checkbox"/> N <input type="checkbox"/>	Obesity:	Y <input type="checkbox"/> N <input type="checkbox"/>

Comments: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____

GENERAL STATUS COMMENT

HEENT: _____ Vision: _____ Pharynx: _____ Dental Devices: _____
 Pulmonary: _____
 Heart: _____
 Abdomen: _____
 Extremity: _____
 Neurologic (if applicable): _____

Comments _____

LABORATORY (if applicable)

H/H: _____	WBC: _____
PT: _____	Chest X-Ray: _____
Mammogram: _____	EKG (Pt over 40): _____
Pregnancy Test: _____	Sodium Chloride: _____
Potassium: _____	CO ₂ : _____
BUN: _____	Creatinine: _____

Comments _____

DIAGNOSES

1. _____
2. _____
3. _____

ASA CLASSIFICATION

- P1 A normal healthy patient
- P2 A patient with mild systemic disease
- P3 A patient with severe systemic disease
- P4 A patient with severe systemic disease that is a constant threat to life

FACILITY SELECTED

- Office-based Surgical Facility
- Ambulatory Surgery Center
- Hospital
-

FIG. 2. Second page of preoperative history and physical examination form.