



Preoperative History & Physical

Please fax to 763-225-9850

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: _____

PLYMOUTH ORTHOPEDIC SURGERY CENTER

Phone: (763) 298-3500

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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:
SPO2: _____ 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 prep evaluation
Most recent evaluation/intervention: _____
 - HTN: Well controlled Other _____
 - Valvular heart disease (or undefined murmur): Lesions/severity _____ Stable Needs prep 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: _____