Use of this form is not required for the preoperative history and physical. It is provided for your convenience for use with healthy patients, and as a guide to the elements required for history and physical. Electronic or dictated notes are welcome provided they include the required components.

Date of Pre-operative____________ Date of Surgery____________

Surgeon ________________________

Procedure/Indication________________________

PMHx/Major Medical Problems:

1.

2.

3.

4.

5.

6.

Past Surgery Hx/Anesthesia – Bleeding – or other complications:

1.

2.

3.

4.

Medications & dosages (including OTC's):

1.

2.

3.

4.

Allergies:

1.

2.

Intolerance:

1.

2.

Habits/Miscellaneous Medical Hx:

EtOH -

Tobacco -

IV drug/Street drug use -

History of Hepatitis or Jaundice -

Bleeding Tendency -

LMP/Pregnancy status -

Code Status __________________

Surgical Waiver Discussed __________________

Family Hx (Mother, Father, Siblings):

Social Hx:

PRE-OPERATIVE HISTORY AND PHYSICAL

ABBOTT NORTHWESTERN HOSPITAL
Allina Hospitals & Clinics
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ASC Phone 612-863-3006 Fax 612-863-6484
Dictation x34545 Off Campus 612-332-0390

PRE-OPERATIVE HISTORY AND PHYSICAL

065-71666 (5/10)
MMC #113

Please include Pt Name with middle initial and birthdate

Patient Name ________________________

Birthdate ________________________

PRE-OPERATIVE HISTORY AND PHYSICAL

REVIEW OF SYSTEMS

Directions: Circle positives/Cross out negatives

CONST.	fever, chills / sweats / fatigue / appetite change temperature intolerance / weight change
EYES	double vision / blurry vision / pain / redness
NOSE & SINUSES MOUTH & THROAT	drainage / congestion / nosebleeds / sinus problems / sores on lips, mouth, tongue, throat dental work / change in voice
RESP	cough / sputum ________ / SOB / wheezing
BREAST	lumps / pain / discharge
CVS	chest pain / heart murmur / DVT / PE edema / palpitations
GI	swallowing difficulties / heartburn / abdominal pain nausea / vomiting / diarrhea / constipation black or bloody stools / hemorrhoids
URINARY	problems urinating / frequent urination
REPRO-DUCTIVE	VD / sexual problems
Male	penile sore, discharge / testicular pain, mass
Female	abnormal bleeding, discharge / sores / pregnancies post-menopausal, hysterectomy / contraception
SKIN	sores / rash
MUSCULO-SKELETAL	joint pain / swelling / stiffness / back pain neck pain
NEURO	headache, head injury / blackout / confusion / seizure / difficulty with vision, speech, walking weakness in arm, leg, face R / L

IMPRESSION / COMMENTS:

PHYSICAL EXAM

Directions: Check appropriate box and explain if indicated.

VS T ______ BP ______ P ______ RR ______

General Wt ______ Ht ______ O_2 Sats ______

	NML/NEGATIVE	ABNL./COMMENTS
EYES	☐ pupils: EOMI	☐ ______
	☐ fundus, conjunctiva	☐ ______
ENT	☐ TM	☐ ______
	☐ teeth: pharynx	☐ ______
	☐ nares	☐ ______
NECK	☐ tenderness; ROM	☐ ______
	☐ thyroid; lymph nodes	☐ ______
RESP	☐ breath sounds	☐ ______
	☐ chest wall motion	☐ ______
	☐ percussion	☐ ______
CVS	☐ RRR	☐ ______
	☐ heart sounds	☐ ______
	☐ carotids	☐ ______
	☐ peripheral pulses	☐ ______
ABD	☐ BS	☐ ______
	☐ tender	☐ ______
	☐ masses: organomegaly	☐ ______
BACK	☐ inspection	☐ ______
	☐ ROM	☐ ______
EXT	☐ edema	☐ ______
	☐ cyanosis; clubbing	☐ ______
	☐ joints	☐ ______
NEURO	☐ orientation	☐ ______
	☐ mood	☐ ______
	☐ gait	☐ ______
	☐ CN's; reflexes	☐ ______
	☐ sensory/motor	☐ ______
	☐ cerebellar fnct	☐ ______
BREAST	☐	☐ ______
GU	☐	☐ ______

Date of Pre-operative Exam ______

Examining Physician Signature ______

Printed Name ______

Pager # ______

Phone # ______

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PRE-OPERATIVE HISTORY AND PHYSICAL

Please include Pt Name with middle initial and birthdate

Patient Name ______

Birthdate ______