# PRE-OPERATIVE HISTORY & PHYSICAL

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Patient's Name

Phone

DOB ______ / ______ / _________

Age

Allergies

Medications

HT

HR

WT

T

BP

RR

## MEDICAL HISTORY

Please specify in the space provided

| | |
|---|---|
| **NEUROLOGICAL** | ■ None |
| **CARDIOVASCULAR** | ■ None |
| **RESPIRATORY** | ■ None |
| **GASTROINTESTINAL** | ■ None |
| **HEME / ONC** | ■ None |
| **ENDOCRINE / RENAL** | ■ None |
| **OTHER** | ■ None |

## SURGICAL HISTORY

Please specify and include dates

______ / ______ / ______

______ / ______ / ______

______ / ______ / ______

______ / ______ / ______

______ / ______ / ______

______ / ______ / ______

______ / ______ / ______

## PHYSICAL EXAM

Please specify in the space provided

| | |
|---|---|
| **PHYSICAL APPEARANCE** | ■ Normal<br>■ Abnormal |
| **HEENT** | ■ Normal<br>■ Abnormal |
| **CARDIOVASCULAR** | ■ Normal<br>■ Abnormal |
| **LUNGS** | ■ Normal<br>■ Abnormal |
| **OTHER** | ■ Normal<br>■ Abnormal |

## IF PATIENT IS A CHILD...

Was this child born prematurely?

■ YES ■ NO

How many weeks premature? ___________

How many weeks on a ventilator? ___________

## PLEASE INCLUDE RESULTS OF MOST RECENT:

■ CBC ■ CHEM ■ PTT / INR ■ CXR ■ EKG ■ OTHER _________

## OPTIMIZED FOR ANESTHESIA

■ **YES** ■ **NO**

**ADDITIONAL COMMENTS / RECOMMENDATIONS**

Physician Printed Name

Phone

Physician Signature

Date