BLAINE ORTHOPEDIC SURGERY CENTER

Preoperative History & Physical

Please fax to 763-302-2251

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
☐	☐	General Appearance:______________
☐	☐	Skin:______________
☐	☐	Head:______________
☐	☐	Eyes:______________
☐	☐	Ears:______________
☐	☐	Nose:______________
☐	☐	Mouth and Throat:______________
☐	☐	Infectious Disease:______________
☐	☐	Psychological:______________

Yes	No	Comments if Yes
☐	☐	Diabetes/Endocrine:______________
☐	☐	Cardiovascular:______________
☐	☐	Respiratory:______________
☐	☐	GI/Hepatitis:______________
☐	☐	Urinary:______________
☐	☐	Neurological:______________
☐	☐	Hematologic:______________
☐	☐	Musculoskeletal:______________
☐	☐	Genito-reproductive:______________

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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: Results____________________.

	Normal	Abnormal - describe
General Appearance	☐	
Skin	☐	
Head	☐	
Eyes	☐	
Ears	☐	
Nose	☐	
Mouth and Throat	☐	
Neck	☐	
Thorax	☐	
Breasts	☐	
Lungs	☐	

	Normal	Abnormal - describe
Heart	☐	
Abdomen	☐	
Genitourinary	☐	
Vaginal	☐	
Rectal	☐	
Musculoskeletal	☐	
Lymphatics	☐	
Blood Vessels	☐	
Neurological	☐	
Other Findings/Diagnosis:		

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 $\geq$ 60 or patients with hypertension, diabetes, peripheral vascular disease, chest pain, CAD if not done in last 6 months)

ECHO:____________________ Stress Testing:____________________

PFT: FEV_1__________ FVC__________

Other Test Results:______________________________

IMPRESSION / ACTIVE PROBLEMS:

☐ CAD: Severity/functional status:____________________ ☐ Stable ☐ Needs preop evaluation
Most recent evaluation/intervention:____________________

☐ HTN: ☐ Well controlled ☐ Other____________________

☐ Valvular heart disease (or undefined murmur): Lesions/severity__________ ☐ Stable ☐ Needs preop 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:______________________________