BLAINE ORTHOPEDIC SURGERY CENTER

Preoperative History & Physical Exam- Anesthesia Services Page 1 of 2

Please fax to 763-302-2251

Patient Name: _____

Date of Birth: _____

Surgeon: _____

Anesthetic: _____

Preop Diagnosis:

_____

_____

CURRENT MEDICATIONS (include herbals and vitamins):

Aspirin / NSAID use in last 5 days: ☐ Yes ☐ No

Steroid use in last 10 days: ☐ Yes ☐ No

Plavix use in last 7 days: ☐ Yes ☐ No

GLP-1 use in last 7 days: ☐ Yes ☐ No

Medications	Dose	Frequency

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PHYSICAL EXAM:

Height:_____ Weight:_____ BMI:_____ Blood Pressure:_____

Pulse:_____ Respirations:_____ LMP:_____

	Within Normal Limits	Abnormal
Heart	☐ _____	☐ _____
Abdomen	☐ _____	☐ _____
Head	☐ _____	☐ _____
Eyes	☐ _____	☐ _____
Ears, Nose, Throat	☐ _____	☐ _____
Musculoskeletal	☐ _____	☐ _____
Mouth and Throat	☐ _____	☐ _____
Lymphatics	☐ _____	☐ _____
Lungs	☐ _____	☐ _____
Neurological	☐ _____	☐ _____

ALLERGIES: _____ ☐ Latex

SOCIAL HISTORY: (☐ tobacco, ☐ alcohol, or ☐ drug use):_____

Family history of anesthesia reactions ☐ Yes ☐ No (if Yes, comment):_____ FH of bleeding disorder ☐ Yes ☐ No

LAB / RADIOLOGY RESULTS:

Hgb:_____ PLT:_____ INR:_____ BUN/Creat:_____

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)

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:_____

☐ Sleep Apnea _____

PLAN: ☐ Patient assessed and approved for procedure in outpatient surgery center setting without additional diagnostic tests or optimization

☐ Patient must undergo additional diagnostic tests as noted below prior to undergoing proposed surgical procedure _____

Provider Signature:_____ **Date:**_____ **Time:**_____

Print Provider Name:_____

Clinic Name and Number:_____