Pre-Operative History & Physical

PATIENT NAME:

DATE OF BIRTH:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

FAMILY HISTORY:

ALLERGIES:

CURRENT MEDICATIONS:

Vital Signs: T____ P____ BP____ R____
O2 Sat____ Ht____ Wt____

PAST MEDICAL HISTORY

Yes	No	
☐	☐	Cerebral Vascular Accident
☐	☐	Neurological Disease
☐	☐	Heart Disease/History of MI
☐	☐	Hypertension
☐	☐	Kidney Disease
☐	☐	GI Disease
☐	☐	Diabetes
☐	☐	Liver Disease
☐	☐	Pulmonary Disease
☐	☐	Smoking History
☐	☐	Bleeding Tendencies
☐	☐	Alcohol Abuse
☐	☐	Other

PREVIOUS SURGERIES/ HOSPITALIZATIONS:

DIAGNOSIS:

REVIEW OF SYSTEMS/PHYSICAL EXAM

WNL	
☐	Cardiovascular________________
☐	Respiratory________________
☐	Gastrointestinal________________
☐	Genitourinary________________
☐	Gynecological________________
☐	Musculoskeletal________________
☐	Endocrinological________________
☐	Neurological________________
☐	Integumentary________________
☐	Other________________

PLAN:

THE ABOVE PATIENT IS MEDICALLY OPTIMIZED FOR THE PROPOSED SURGERY:

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Physician's Signature

____

Printed Physician's Name

____

Date