Name: _____

Address: _____

Phone #: _____

Record #: _____

MHSC# _____

Date of Birth: _____

Additional Requirements:

EKG >50yrs ☐ Breast Screening☐

CXR >65yrs ☐ Pap test ☐

Laboratory:

Serum Glucose ☐ Hgb only ☐

Electrolytes ☐ LFT's ☐

Urea/Creatinine/eGFR ☐ Coags ☐

CBC ☒

Diagnosis:

Date of Surgery:

Surgical Procedure:

History of Present Illness:

Significant PMHx:

Family History ☐ Cancer ☐ Cardiovascular ☐ Other

Surgical History:

Family History of Anesthetic Problems	☐ No	☐ Yes	Comment
Past History of Anesthetic Problems	☐ No	☐ Yes	Comment
History of MH	☐ No	☐ Yes	Comment
History of Pseudocholinesterase Deficiency	☐ No	☐ Yes	Comment

Present Medication:

Allergies:

Blood/Body Precautions	No	Yes		No	Yes
Previous blood transfusion	☐	☐			
HIV testing/result	☐	☐	High risk group for aids	☐	☐
Refused as blood donor	☐	☐	History of hepatitis	☐	☐

Past medical history/review of systems

Cardiovascular

	No	Yes	Inactive	Comments
angina				
exercise limitation				
previous m.i				
congestive heart failure				
murmur				
arrhythmia				
hypertension				
peripheral vascular disease				
pace maker				
other				

Gastro Intestinal

	No	Yes	Inactive	Comments
hiatus hernia/reflux				
peptic ulcer				
melena				
hematemasis				
abdominal pain				
inflammatory bowel disease				
jaundice				

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Respiratory

	No	Yes	Inactive	Comments
dyspnea				
wheezing/asthma				
chronic bronchitis				
emphysema				
hemoptysis				
sleep apnea				

Neurological

	No	Yes	Inactive	Comments
headache				
dementia				
tia				
cva				
seizures				
mental retardation				

Musculoskeletal

	No	Yes	Inactive	Comments
osteoarthritis				
rheumatoid arthritis				
other				

Dermatology

skin rash				
cancer				

Genito-Urinary

	No	Yes	Inactive	Comments
dysuria				
hematuria				
renal disease				
menstrual cycle				Imp

Hematological

	No	Yes	Inactive	Comments
bleeding disorder				
anemia				
other				

Endocrine

	No	Yes	Inactive	Comments
diabetes				
thyroid disease				
other				

Physical Examination

Height	Weight	Heart Rate	B.P.	Temp.

	Normal	Abnormal	Comments
general appearance			
head and neck			
central nervous system			
respiratory			
cardiovascular			
breasts			
abdomen			
back & extremities			
skin			
lymph nodes			
rectal			
pelvic/external genitalia			

ASA Classification 1 2 3 4 5 (Circle one)

Date of examination _____ Examining Physician / Nurse Practitioner Name _____

Phone _____ Address _____ Signature _____

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