

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: _____ Smoker Y N ___/ppd

Family History Cancer Cardiovascular Other

Previous Surgeries: Y N _____
 Family History of Anesthetic Problems No Yes Comment
 Past History of Anesthetic Problems No Yes Comment
 History of Malignant Hyperthermia No Yes Comment
 History of Pseudocholinesterase Deficiency No Yes Comment

Present Medication: _____ Allergies: _____

Blood/Body Precautions	No	Yes		No	Yes
Previous blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>			
HIV testing/result	<input type="checkbox"/>	<input type="checkbox"/>	High risk group for AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Refused as blood donor	<input type="checkbox"/>	<input type="checkbox"/>	History of hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

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				
hematemesis				
abdominal pain				
inflammatory bowel disease				
jaundice				

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				

Physical Examination

	Weight		Heart Rate	B.P.	Temp.
	Normal	Abnormal			
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 _____

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				