PRE-OPERATIVE PHYSICAL / ASSESSMENT Date: _____

Name:_____ Phone #: _____ Cell #: _____

Height: _____Weight: _____ Age: _____ Language: ☐ English ☐ Other _____

Medication Allergies: _____**Primary Care MD:**_____

Do you have or have you ever had any of the following? Place a check in the box that applies:

Nervous System	Epilepsy/Seizures/Fainting spells	□ Yes	□ No	**GI/GU**	Hiatal Hernia	□ Yes	□ No
	Stroke	□ Yes	□ No		Stomach ulcer	□ Yes	□ No
	Loss of Consciousness	□ Yes	□ No		Kidney Disease	□ Yes	□ No
	ADHD/ADD	□ Yes	□ No		Unexplained Recent Weight		
	Cerebral Palsy	□ Yes	□ No		Loss/Gain:	□ Yes	□ No
	Head Injury	□ Yes	□ No		Gastric Reflux	□ Yes	□ No
	Headaches/Migraines	□ Yes	□ No		Indigestion	□ Yes	□ No
					Motion Sickness	□ Yes	□ No
Psychosocial	Anxiety/Depression	□ Yes	□ No	**Endocrine**	Diabetes	□ Yes	□ No
	Counseling Service	□ Yes	□ No		Thyroid Disease	□ Yes	□ No
	Mental Illness	□ Yes	□ No		Insulin Dependent	□ Yes	□ No
					Hypoglycemia	□ Yes	□ No
Heart	High Blood Pressure	□ Yes	□ No	**Musculo-**	Arthritis	□ Yes	□ No
	Chest Pain	□ Yes	□ No	**Skeletal**	Painful Stiff Joints	□ Yes	□ No
	Angina	□ Yes	□ No		Prosthesis: _____	□ Yes	□ No
	Heart Attack	□ Yes	□ No		Back Pain	□ Yes	□ No
	Pacemaker/AID	□ Yes	□ No		Metal Implants: _____	□ Yes	□ No
	Mitral Valve Prolapse	□ Yes	□ No		Physical Limitations:	□ Yes	□ No
	Heart Murmur	□ Yes	□ No	**Blood**	Bleeding Disorder	□ Yes	□ No
	Irregular Heartbeat/	□ Yes	□ No		Previous Blood Transfusions	□ Yes	□ No
	Palpitations/Skipped beats	□ Yes	□ No		Eye Glaucoma	□ Yes	□ No
	Heart surgery	□ Yes	□ No		Eye – Other	□ Yes	□ No
Lung	Asthma	□ Yes	□ No	**Airway**	Problem Opening Mouth Wide	□ Yes	□ No
	Hay fever/Sinus	□ Yes	□ No		Problem Turning Head in Any		
	Emphysema/COPD	□ Yes	□ No		Direction	□ Yes	□ No
	Shortness of Breath	□ Yes	□ No		Sleep Apnea / Snoring	□ Yes	□ No
	Croup	□ Yes	□ No	**Dental**	Bridges, Partials, Dentures	□ Yes	□ No
	Previous Smoke: Quit _____				Loose or Missing Teeth	□ Yes	□ No
	Smoke: _____ Cigs per day	_____	Yrs		TMJ	□ Yes	□ No
	Bronchitis	□ Yes	□ No		Any reactions to Latex?	□ Yes	□ No
	Recent Cold or Cough	□ Yes	□ No	**Allergies**	Medications	□ Yes	□ No
	TB	□ Yes	□ No		Dyes/Tape	□ Yes	□ No
	Pneumonia	□ Yes	□ No		Shellfish	□ Yes	□ No
	Chew Tobacco	□ Yes	□ No		Foods	□ Yes	□ No
Anesthesia	Nausea/Vomiting After Anesthesia	□ Yes	□ No	**Liver**	Hepatits/Jaundice/Liver Disease	□ Yes	□ No
	Family history of Anesthesia				Alcoholic beverages/day: ___	□ Yes	□ No
	Problems	□ Yes	□ No		Recreational drugs	□ Yes	□ No
GYN	Last Menstrual period: _____ Pregnancy Test: _____						

Skin: Have you ever had MRSA □Yes □No Treat by: _____
Open Lesions/Boils □Yes □No Description: _____
Physician Notified: □Yes □No

Above completed by patient: □Yes □No
Reviewed with patient by RN □Yes □No
Nurse signature_____
Date _____

Most Recent Hospital Admissions/Previous Surgeries

Serious Illness / Cancer:

Clinical Use Only **Clinical Use Only** **Clinical Use Only** **Clinical Use Only**

Arrival Time: _____NPO After: _____Clear Liquids Until: _____ ☐No valuables/jewelry ☐Comfortable Clothes

Adult Driver/Care Giver: _____ ☐Bring: Meds, Crutches/Walker, Picture I.D., Ins Cards ☐Patient Medication Reconciliation List completed

☐ Meds in AM with small sip of water with the exception of _____ Left message on phone _____

Notes_____

_____

RN: _____ **Date:** _____ **Pt. BMI:** _____ **Hx updated/reviewed** _____ **Arrival time** _____

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