PREOPERATIVE EVALUATION FORM

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Last Name , First Name ______________________ M.I. ______ Age ______ Sex ☐ M ☐ F

8 digit CSN no. | | | | | | | | | admission date ______________

9 digit Med rec no. | | | | | | | | |

date of birth ______________ SSN: ______________

admitting diagnosis ______________

procedure(s) planned ______________

location ☐ Pres Main ☐ Pres Day ☐ Kaseman

status ☐ Ambulatory outpatient ☐ Bedded outpatient ☐ Inpatient

pay source / insurance ☐ cosmetic self-pay ☐ PHP ☐ Pres Salud ☐ Other:

primary care physician ______________

consultants ______________

Phone contact: Home ______________ Work ______________ Cell ______________

Contact name if minor: ______________ relationship ______________

Emergency contact: ______________ phone ______________

Discharge support: ______________ phone ______________

City of Residence ______________ staying at ______________

language ______________ interpreter ______________

NPO per guidelines ______________ arrival time ______________

Completed by ______________ Date ______________

Notes

Medications – prescription and OTC – (✓) if instructed to take in AM of surgery with sip of water

Name/dose		route	frequency	comment	(✓)
1					
2					
3					
4					
5					
6					
7					
8					

Previous Surgery *and* **Hospitalizations** (dates) or attach list

1	
2	
3	
4	
5	
6	

Current Active Medical Problems:

1	
2	
3	
4	
5	
6	

Allergies or Sensitivities to medications, latex, topicals, OTC, etc.

		no	yes	describe reaction
Medications				
1				
2				
3				
4				
latex				
topicals				
tape				
food				
OTC				
environmental				
other				

Pertinent Past Medical History and **Review of Systems**

	yes	no	explain
Anemia			
Anesthesia problems			
Arrhythmia, irreg heart beat			
Arthritis			
Asthma			
Bleeding problems			
Cancer			
Circulation problems			
Dentures/loose teeth			
Diabetes			
DVT - blood clots			
GE Reflux			

	yes	no	explain
Heart disease, MI			
Hormone replacement			
Hypertension			
Jehovah Witness			
Last menstrual period			
Pneumonia			
Psych Depression Anxiety			
Pulmonary embolus			
Sleep apnea or snoring			
Thyroid			
Transfusions			
Wound infections			

MH malignant hyperthermia			self or family, explain:
Exposure to infection			TB HIV Hepatitis STD's MRSA Other:
Other/Explain			

Social History	
occupation	
marital status	
children	
lives with	
lives where	
language/interpreter	

Habits	
smoking	how much When stopped
ETOH	

Family History*: ASK: birth defects, heart disease, anesthesia, cancer, malignant hyperthermia*
☐ No ☐ Yes:

Physical Examination*:*					
BP	*Pulse*	*Temp*	*Height*	*Weight Kg*	*Weight lbs*
Lungs:		*Heart:*		*Other:*	
VS, HEENT, NECK, LUNGS, HEART, ABD, EXT, GYN, GU, NEURO					

Tests	*Date*	*Result*	*Comments*
Labs		*Hb* ______ *Hct* _____ *K+* _____	
EKG			
medical clearance			
xrays/other			