

Use of this form is not required for the preoperative history and physical. It is provided for your convenience for use with healthy patients, and as a guide to the elements required for history and physical. Electronic or dictated notes are welcome provided they include the required components.

Date of Pre-operative _____ Date of Surgery _____

Surgeon _____

Procedure/Indication _____

PMHx/Major Medical Problems:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Past Surgery Hx/Anesthesia – Bleeding – or other complications:

- 1.
- 2.
- 3.
- 4.

Medications & dosages (including OTC's):

- 1.
- 2.
- 3.
- 4.

Allergies:

- 1.
- 2.

Intolerance:

- 1.
- 2.

Habits/Miscellaneous Medical Hx:

EtOH -
Tobacco -
IV drug/Street drug use -
History of Hepatitis or Jaundice -
Bleeding Tendency -
LMP/Pregnancy status -

Code Status _____

Surgical Waiver Discussed _____

Family Hx (Mother, Father, Siblings):

Social Hx:



ABBOTT NORTHWESTERN HOSPITAL

Allina Hospitals & Clinics

PCCC Phone 612-863-3030 Fax 612-863-3514

ASC Phone 612-863-3006 Fax 612-863-6484

Dictation x34545 Off Campus 612-332-0390

PRE-OPERATIVE HISTORY AND PHYSICAL

Please include Pt Name with middle initial and birthdate

Patient Name _____

Birthdate _____

REVIEW OF SYSTEMS		PHYSICAL EXAM	
Directions: Circle positives/Cross out negatives		Directions: Check appropriate box and explain if indicated.	
CONST.	fever, chills / sweats / fatigue / appetite change temperature intolerance / weight change	VS	T _____ BP _____ P _____ BB _____
EYES	double vision / blurry vision / pain / redness	General	Wt _____ Ht _____ O ₂ Sats _____
NOSE & SINUSES MOUTH & THROAT	drainage / congestion / nosebleeds / sinus problems / sores on lips, mouth, tongue, throat dental work / change in voice	NML/NEGATIVE ABNL./COMMENTS	
RESP	cough / sputum _____ / SOB / wheezing	EYES	<input type="checkbox"/> pupils: EOMI _____ <input type="checkbox"/> fundus, conjunctiva _____
BREAST	lumps / pain / discharge	ENT	<input type="checkbox"/> TM _____ <input type="checkbox"/> teeth: pharynx _____ <input type="checkbox"/> nares _____
CVS	chest pain / heart murmur / DVT / PE edema / palpitations	NECK	<input type="checkbox"/> tenderness; ROM _____ <input type="checkbox"/> thyroid; lymph nodes _____
GI	swallowing difficulties / heartburn / abdominal pain nausea / vomiting / diarrhea / constipation black or bloody stools / hemorrhoids	RESP	<input type="checkbox"/> breath sounds _____ <input type="checkbox"/> chest wall motion _____ <input type="checkbox"/> percussion _____
URINARY	problems urinating / frequent urination	CVS	<input type="checkbox"/> RRR _____ <input type="checkbox"/> heart sounds _____ <input type="checkbox"/> carotids _____ <input type="checkbox"/> peripheral pulses _____
REPRO-DUCTIVE Male Female	VD / sexual problems penile sore, discharge / testicular pain, mass abnormal bleeding, discharge / sores / pregnancies post-menopausal, hysterectomy / contraception	ABD	<input type="checkbox"/> BS _____ <input type="checkbox"/> tender _____ <input type="checkbox"/> masses: organomegaly _____
SKIN	sores / rash	BACK	<input type="checkbox"/> inspection _____ <input type="checkbox"/> ROM _____
MUSCULO-SKELETAL	joint pain / swelling / stiffness / back pain neck pain	EXT	<input type="checkbox"/> edema _____ <input type="checkbox"/> cyanosis; clubbing _____ <input type="checkbox"/> joints _____
NEURO	headache, head injury / blackout / confusion / seizure / difficulty with vision, speech, walking weakness in arm, leg, face R / L	NEURO	<input type="checkbox"/> orientation _____ <input type="checkbox"/> mood _____ <input type="checkbox"/> gait _____ <input type="checkbox"/> CN's; reflexes _____ <input type="checkbox"/> sensory/motor _____ <input type="checkbox"/> cerebellar fnct _____
IMPRESSION / COMMENTS:		BREAST	<input type="checkbox"/> _____
		GU	<input type="checkbox"/> _____
		Date of Pre-operative Exam _____	
		Examining Physician Signature _____	
		Printed Name _____	
		Pager # _____	
		Phone # _____	

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