

# Pre-Operative History & Physical

PATIENT NAME:

DATE OF BIRTH:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

FAMILY HISTORY:

ALLERGIES:

CURRENT  
MEDICATIONS:

Vital Signs: T\_\_\_\_ P\_\_\_\_ BP\_\_\_\_ R\_\_\_\_  
O2 Sat\_\_\_\_ Ht\_\_\_\_ Wt\_\_\_\_

## PAST MEDICAL HISTORY

## REVIEW OF SYSTEMS/PHYSICAL EXAM

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Vascular Accident
<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/History of MI
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	GI Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disease
<input type="checkbox"/>	<input type="checkbox"/>	Smoking History
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendencies
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Other

### WNL

Cardiovascular\_\_\_\_\_

Respiratory\_\_\_\_\_

Gastrointestinal\_\_\_\_\_

Genitourinary\_\_\_\_\_

Gynecological\_\_\_\_\_

Musculoskeletal\_\_\_\_\_

Endocrinological\_\_\_\_\_

Neurological\_\_\_\_\_

Integumentary\_\_\_\_\_

Other\_\_\_\_\_

PREVIOUS SURGERIES/  
HOSPITALIZATIONS:

DIAGNOSIS:

PLAN:

**THE ABOVE PATIENT IS MEDICALLY  
OPTIMIZED FOR THE PROPOSED  
SURGERY:**

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Physician's Signature

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Date