White Plains Hospital

41 EAST POST ROAD • WHITE PLAINS, NY 10601

Please Fax to 914-681-2936

Page 1
PREOPERATIVE HISTORY AND PHYSICAL

Patient Name: _____

Date of Birth: _____

Gender: ☐ M ☐ F

SURGICAL PROCEDURE: _____

DATE OF SURGERY: _____ SURGEON: _____

INDICATION: _____

PAST MEDICAL HISTORY: _____

Allergies: **Medications:** ☐ No ☐ Yes **Latex:** ☐ No ☐ Yes **IV Contrast:** ☐ No ☐ Yes

Describe: _____

Medical Illnesses: _____

Check if positive and describe:

Cardiac Hx: None ☐ CAD ☐ Describe: _____

S/p CABG ☐ (no. vessels _____ yr. _____) S/p percutaneous coronary intervention ☐

(no. stents _____ yr. _____) Type: BMS ☐ DES ☐

Valvular heart disease ☐ Describe: _____

Arrhythmia ☐ Describe: _____ Cardiomyopathy ☐ Describe: _____

Cardiac Testing: Echocardiogram ☐ (yr. _____) Describe: _____

Stress test ☐ yr. _____ echo ☐ nuclear ☐ Describe: _____

Angiography ☐ yr. _____ Describe: _____

Pacemaker ☐ No ☐ Yes Company Name: _____ Pacemaker Dependent ☐ No ☐ Yes

AICD ☐ No ☐ Yes Company Name: _____

Reproductive History: LMP _____

Menopausal: ☐ No ☐ Yes Date: _____ Tubal Ligation: ☐ No ☐ Yes Hysterectomy: ☐ No ☐ Yes

Operations / Injuries (List yr.): _____

Medications (List with dosage/frequency): _____

Anesthetic Complications: ☐ No ☐ Yes Describe: _____

SUBSTANCE USE:

Habits: Tobacco: ☐ No ☐ Yes Pack / yrs: _____ ☐ Yr quit: _____

ETOH: ☐ No ☐ Yes Quantity: _____

Drugs: ☐ No ☐ Yes Type: _____

IMMUNIZATIONS:

Tetanus Booster: ☐ No ☐ Yes Yr. _____

Pneumovax: ☐ No ☐ Yes Yr. _____

Influenza: ☐ No ☐ Yes Yr. _____

Hepatitis B: ☐ No ☐ Yes Yr. _____

OTHER HEALTH MAINTENANCE: Colonoscopy yr. _____ Pap yr ___ Mammo yr ___ Bone Den. yr _____ PSA yr_____

Smoking Cessation Counseling Y/N/NA Dietary Restrictions _____ Regular Exercise Y/N _____

FAMILY HX: _____

107-015 (05/11)

White Plains Hospital

41 EAST POST ROAD • WHITE PLAINS, NY 10601

Please Fax to 914-681-2936

Patient Name: _____

Date of Birth: _____

Page 2
PREOPERATIVE HISTORY AND PHYSICAL

ROS: (Check, if POSITIVE)

General: ☐ clotting abnormality ☐ transfusion ☐ bleeding with surgery ☐ fever ☐ chills ☐ change in weight
☐ sweats ☐ fatigue ☐ sleep disturbance ☐ Other _____

Head & Neck: ☐ HA ☐ tenderness ☐ "swollen glands" ☐ Other _____

Eyes: ☐ glasses: near ☐ far ☐ sighted ☐ contacts ☐ glaucoma ☐ cataracts ☐ Other _____

Ears: ☐ hearing loss ☐ tinnitus ☐ Other _____

CV: ☐ murmur (describe: _____) ☐ chest pain ☐ DOE ☐ orthopnea ☐ PND ☐ palpitations
☐ claudication ☐ endocarditis ☐ arrhythmia (describe: _____) ☐ Other _____

Chest: ☐ cough ☐ hemoptysis ☐ SOB ☐ wheezing ☐ stridor ☐ pneumonia ☐ Other _____

Breasts: ☐ discharge ☐ pain ☐ lumps ☐ Other _____

GU: ☐ UTI ☐ nephrolithiasis ☐ hematuria ☐ dysuria ☐ nocturia ☐ frequency ☐ hesitancy ☐ incontinence ☐ BPH
☐ prostatitis ☐ abnormal vaginal bleeding ☐ fibroids G _____ P _____ ☐ Other _____

GI: ☐ colon polyps ☐ constipation ☐ diarrhea ☐ hemorrhoids ☐ rectal bleeding ☐ melena ☐ Δ in bowel habit
☐ dysphagia ☐ heartburn ☐ diverticulosis ☐ diverticulitis ☐ jaundice ☐ hepatitis ☐ Other _____

MS: ☐ back problems ☐ weakness ☐ arthritis ☐ gout ☐ Other _____

Neuro: ☐ numbness ☐ tingling ☐ burning ☐ tremors ☐ LOC ☐ paralysis ☐ memory loss ☐ unsteady gait

Psychiatric: ☐ depression ☐ anxiety ☐ obsessive behavior ☐ delusions ☐ hallucinations ☐ abnormal affect

Endocrine: ☐ thyroid nodule ☐ polydipsia ☐ polyuria ☐ cold/heat intolerance ☐ Other _____

Skin: ☐ itching ☐ hives ☐ easy bruisability ☐ rash ☐ describe: _____

PHYSICAL EXAM:

V.S.: BP _____ P _____ RR _____ Temp _____ Ht _____ Wt _____

Check if ABNORMAL and describe

General Appearance ☐ Describe: _____

HEENT: Fundi ☐ TMs ☐ Pharynx ☐ Teeth ☐ (dentures: ☐ No ☐ Yes)
Describe: _____

NECK: Thyroid ☐ Jugular vein ☐ Carotid ☐ Describe: _____

CHEST: AP Diameter ☐ Describe: _____

BREASTS: ☐ Describe: _____

LUNGS: ☐ Describe: _____

COR: Rhythm ☐ Heart Sounds ☐ Murmur ☐ Describe: _____

ABDOMEN: Bowel Sounds ☐ Liver ☐ Spleen ☐ Tenderness ☐ Masses ☐ Hernias ☐
Describe: _____

BACK: ☐ Describe: _____

GENITALIA: ☐ Describe: _____

RECTAL: ☐ Describe: _____

PELVIC: ☐ Describe: _____

EXTREMITIES: ☐ Describe: _____

PERIPHERAL PULSES: ☐ Describe: _____

SKIN: ☐ Describe: _____

LYMPH NODES: ☐ Describe: _____

NEURO: Strength ☐ Sensation ☐ DTRs ☐ Mental Status ☐ Rigidity ☐ Tremor ☐ Describe: _____

EKG: Normal ☐ Abnormal ☐ Describe: _____

CXR: Normal ☐ Abnormal ☐ Describe: _____

LAB: Normal ☐ Abnormal ☐ Describe: _____

107-015 (05/11)

White Plains Hospital
41 EAST POST ROAD • WHITE PLAINS, NY 10601

Please Fax to 914-681-2936

Page 3
PREOPERATIVE HISTORY AND PHYSICAL

Patient Name:_____
Date of Birth:_____

SLEEP APNEA SCREENING

☐ None ☐ Mild ☐ Moderate ☐ Severe

If using CPAP instruct to bring device to hospital on day of surgery

High Risk for Sleep Apnea - 3 or more of the following risk factors

Snoring (loud enough to be heard outside the room), **Tired** (frequently tired during the day or falls asleep), **Obstruction** - witnessed obstruction of breathing at night, **HTN**, **Male**, **BMI > 35, Neck circumference** > 17 inch male/16 inch female, **Age > 50** ☐ Yes ☐ No

If high risk, a sleep study or pulmonary consult is recommended

PATIENT REQUIRES ANTIBIOTIC PROPHYLAXIS FOR ENDOCARDITIS:

☐ No ☐ Yes Antibiotics: _____

POSTOP PRECAUTION FOR SUBSTANCE WITHDRAWAL:

Alcohol ☐ Nicotine ☐ Street drug/Narcotic ☐ Name_____ ☐ Benzodiazepines

GENERAL RECOMMENDATIONS:_____

_____

_____

_____

_____

_____

_____

PATIENT IS MEDICALLY OPTIMIZED FOR ANESTHESIA AND SURGERY:

☐ No ☐ Yes_____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone Number: _____ FAX Number: _____

Physician's Signature: _____ Date:_____ Time:_____

107-015 (05/11)