HOSPITAL FOR SPECIAL SURGERY

Name:
HSS MRN:
DOB:
Type of Surgery:
Date of Planned Surgery:

History & Physical

Chief Complaint:

HPI:

Past Medical History:

Past Surgical History:

Medications:

Allergies:

Social History

- **Tobacco** ☐ Yes ☐ No If yes, how much?_____
- **Alcohol** ☐ Yes ☐ No If yes_____drinks/week
- **Other Drugs** ☐ Yes ☐ No If yes, please specify: _____

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Family History:

• Bleeding History ☐ Yes ☐ No • Anesthesia problems ☐ Yes ☐ No

Review of Systems:

Obstructive Sleep Apnea

• STOP-Bang Score: _____ (see STOP-Bang Sleep Apnea Questionnaire)

• Diagnosed Sleep Apnea? ☐ Yes ☐ No If yes, uses CPAP? ☐ Yes ☐ No

Physical Exam:

• Vital Signs: P _____ BP _____ R _____ Wt _____ HT _____ Pulse Ox _____

• Skin: _____ • Lungs: _____ • Ext: _____

• HEENT: _____ • Abd: _____ • Neuro: _____

• Lungs: Normal Breath? ☐ Yes ☐ No If no, explain _____

• Cardiovascular: Normal Rhythm? ☐ Yes ☐ No If no, explain _____

Murmur ☐ Yes ☐ No If yes, explain _____

Results:

Impression:

Medically Optimized for Surgery? ☐ **Yes** ☐ **No**

Plan:

1. Medications to take the morning of surgery: _____
2. Medications to stop before surgery: _____
3. Recommendations: _____

Signature: _____ **Print Name:** _____

Date: _____ **Phone Number:** _____