UM Upper Chesapeake Health

PRE-OPERATIVE SURGICAL EVALUATION

Name: _____ DOB: _____ Date: _____

Referring Physician: _____

Proposed Procedure: _____

History of Present Illness: _____

_____

Past Medical History: _____

_____

_____

Past Surgical History: _____

_____

Medications: ☐ Medication List reviewed and **attached**

☐ Medication List reviewed and listed below

_____

_____

_____

Allergies: _____

_____

_____

FAMILY HISTORY

	Yes	No	Family Member
Heart Disease	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____

SOCIAL HISTORY

	Yes	No	Quantity
Cigarettes	☐	☐	_____
Alcohol	☐	☐	_____
Caffeine	☐	☐	_____

REVIEW OF SYSTEMS

☐ All systems were reviewed and are negative unless noted below or mentioned elsewhere in this form.

☐ Constitutional	☐ Cardiovascular	☐ Gastrointestinal	☐ Integumentary
☐ Eyes	☐ Respiratory	☐ Genitourinary	☐ Neurological
☐ ENT	☐ Musculoskeletal	☐ Psychiatric	☐ Endocrine

PHYSICAL EXAMINATION

General Appearance: _____

☐ Vital signs: Height: _____ Weight: _____

BMI: _____ BP _____

Pulse _____ Temp _____

HEENT: _____

Neck: _____

Lungs: _____

Cardiac: _____

Tests Reviewed: Labs_____

EKG_____ Chest X-ray_____

LMP: (Last menstrual period): _____

Abdomen: _____

Extremities: _____

Neuro: _____

Pelvic Exam: _____

_____

_____

Other:_____

Impression/Plan: _____

_____

_____

_____ _____ _____

Signature Date Time

_____

Dictation ID #, Printed Name or Stamp

70614 5/16