PRE-OP PHYSICAL ASSESSMENT

Procedure date/time:________________________________
Arrival time:_____________ NPO______ sips H20________
Phone number:_____________Call Attempted @__________
Procedure: ____

History obtained from: Patient Spouse Other____________ Language: ☐English ☐Other__________________________

Height: _______Weight: ______ Age/Sex: _________ Adult Driver/Care Giver: ______________________________

☐No Eye Make Up ☐Comfortable Clothes ☐No Nail Polish/Jewelry ☐Eyes: Sunglasses and s.s. shirt

☐Bring: Advanced Directives, Living Will, Meds, Crutches/Walker, Assisting devices, I.D., insurance Cards

Were you provided with a packet of information from the Doctor's office including Advanced Directives,Physician Financial Disclosureship, and Patient Rights and Responsibilities? Yes □ No □ If not, may we e-mail it to you now? Yes □ No □ E-mail address: _____________________ sent: ☐

What illnesses are you taking prescription medication for?

What illnesses are you currently being treated for by a physician?

Do you have or have you ever had any of the following: Place a check in the box that applies								**Comments**
Nervous System	Epilepsy/Seizures	□ Yes	□ No	ADHD/ADD	□ Yes	□ No		
	Stroke/TIA	□ Yes	□ No	Cerebral Palsy	□ Yes	□ No		
	Multiple Sclerosis	□ Yes	□ No	Headaches/Migraine	□ Yes	□ No		
Psycho-social	Treated for Anxiety/Depression	□ Yes	□ No	Panic Attacks	□ Yes	□ No		
	Schizophrenia	□ Yes	□ No	Feel safe in home?	□ Yes	□ No		
Heart	High Blood Pressure	□ Yes	□ No	MVP	□ Yes	□ No		
	Angina	□ Yes	□ No	Irr. HR/Palpitations	□ Yes	□ No		
	Heart Attack	□ Yes	□ No	Heart surgery	□ Yes	□ No		Stents ____________
	Pacemaker/IAD	□ Yes	□ No					CABG____________
Lung	Asthma	□ Yes	□ No	Sleep Apnea	□ Yes	□ No		
	Emphysema/COPD	□ Yes	□ No	Recent Cold/Cough	□ Yes	□ No		
	Shortness of Breath	□ Yes	□ No	Active TB	□ Yes	□ No		
	Smoker:	□ Yes	□ No	Previous Smoke?	□ Yes	□ No		
	Packs/Cigarettes/Day	____/	Day	Quit when?_______				
Liver	History of Hepatitis/Jaundice/Liver Dx: ______________________________				□ Yes	□ No		
	History of alcohol abuse				□ Yes	□ No		
	Do you use marijuana, speed, cocaine, hallucinogens, etc?				□ Yes	□ No		
GYN	LMP: _________________________________			<50yo: Pregnancy Test: □Yes DOS □will sign consent □NA				
GI/GU	Stomach Ulcer	□ Yes	□ No	Gastric Reflux	□ Yes	□ No		
	Unexplained Rec. weight loss/gain	□ Yes	□ No	Kidney Disease	□ Yes	□ No		
Musculo-Skeletal	Rheumatoid Arthritis	□ Yes	□ No	Metal Implants	□ Yes	□ No		
	Prosthesis:__________	□ Yes	□ No	Physical Limitations	□ Yes	□ No		
	Myasthenia gravis	□ Yes	□ No					
Endocrine	Diabetes: □ Type I □ Type II	□ Yes	□ No	Take Insulin	□ Yes	□ No		**BS_______**
	Thyroid Disease	□ Yes	□ No	Hypoglycemia	□ Yes	□ No		**Time_____**
Blood	Are you taking any blood thinners?	□ Yes	□ No	Bleeding Disorder	□ Yes	□ No		
	Last time taken?_______________							
Airway	Problem Opening Mouth Wide	□ Yes	□ No	TMJ	□ Yes	□ No		
	Problem Turning Head in any direction □ Yes □ No							
Dental	Bridges,Crowns,Partials,Dentures	□ Yes	□ No	Loose or Missing Teeth	□ Yes	□ No		
Allergies	Any reactions to Latex?	□ Yes	□ No	Shellfish/Foods	□ Yes	□ No		
	Medications	□ Yes	□ No	Dyes/Tape	□ Yes	□ No		
Anesthesia	Nausea/Vomiting after anesthesia	□ Yes	□ No	Family History of				
	Motion Sickness	□ Yes	□ No	Anesthesia Problems	□ Yes	□ No		
	Difficult Intubation?	□ Yes	□ No	Personal hx of anesthesia				
				problems	□ Yes	□ No		

Skin: Have you ever had **MRSA** □ Yes □ No **Physician/Date**:_____________________________________
Rashes/Open Lesions/Boils: □ Yes □ No Description:________________________________
Physician notified: □ Yes □ No

Primary Care MD:

Previous Surgeries / Serious Illness / Cancer:

Most recent hospital admission:

Medication Instructions: □ See Med Reconciliation Form

RN Signature:	**Date:**