

Memorial Hospital Experience Matters	DATE	PATIENT LABEL
	<b>SURGICAL HISTORY &amp; PHYSICAL EXAMINATION</b>	
Age _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Chief Complaint \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Surgery Planned \_\_\_\_\_ Date Planned \_\_\_\_\_

Surgeon \_\_\_\_\_  
 \_\_\_\_\_

History of Present Illness \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Past Medical History \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Past Surgical History \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Family History \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medications / Herbals	Dosage	Frequency	Medications / Herbals	Dosage	Frequency

Allergies \_\_\_\_\_  
 \_\_\_\_\_

**REVIEW OF SYSTEMS**

Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Cardiovascular</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Pulmonary</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Metabolic</b>	
<input type="checkbox"/> <input type="checkbox"/>	MI	<input type="checkbox"/> <input type="checkbox"/>	Smoking Hx	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	
<input type="checkbox"/> <input type="checkbox"/>	Hypertension	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Thyroid	
<input type="checkbox"/> <input type="checkbox"/>	Arrhythmia	<input type="checkbox"/> <input type="checkbox"/>	COPD / Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Steroid Use	
<input type="checkbox"/> <input type="checkbox"/>	Angina / CAD	<input type="checkbox"/> <input type="checkbox"/>	SCB	<input type="checkbox"/> <input type="checkbox"/>	Obesity	
<input type="checkbox"/> <input type="checkbox"/>	CHF	<input type="checkbox"/> <input type="checkbox"/>	Cough	<input type="checkbox"/> <input type="checkbox"/>	Arthritis	
<input type="checkbox"/> <input type="checkbox"/>	Valvular Disease	<input type="checkbox"/> <input type="checkbox"/>	Wheezing	<input type="checkbox"/> <input type="checkbox"/>	Other _____	
<input type="checkbox"/> <input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/> <input type="checkbox"/>	PND / Orthopnea			<b>Gastrointestinal</b>
<input type="checkbox"/> <input type="checkbox"/>	Past Cardiac Disease	<input type="checkbox"/> <input type="checkbox"/>	Sleep Apnea			GE Reflux / Hiatal Hernia
<input type="checkbox"/> <input type="checkbox"/>	Pacemaker / AICD	<input type="checkbox"/> <input type="checkbox"/>	Other _____	<input type="checkbox"/> <input type="checkbox"/>	<b>Neuromuscular</b>	Bowel Obstruction
<input type="checkbox"/> <input type="checkbox"/>	CABG / PTCA			<input type="checkbox"/> <input type="checkbox"/>	Seizure	Hepatitis / Jaundice
<input type="checkbox"/> <input type="checkbox"/>	Chest Pain			<input type="checkbox"/> <input type="checkbox"/>	CVA / TIA	Nausea / Vomiting
<input type="checkbox"/> <input type="checkbox"/>	Palpitations	<input type="checkbox"/> <input type="checkbox"/>	<b>Renal</b>	<input type="checkbox"/> <input type="checkbox"/>	Elevated ICP	Diarrhea
<input type="checkbox"/> <input type="checkbox"/>	Edema	<input type="checkbox"/> <input type="checkbox"/>	Renal Failure /	<input type="checkbox"/> <input type="checkbox"/>	Cerebrovascular Disease	Other _____
<input type="checkbox"/> <input type="checkbox"/>	Other _____	<input type="checkbox"/> <input type="checkbox"/>	Renal Insufficiency	<input type="checkbox"/> <input type="checkbox"/>	Dementia / Depression	
	<b>Drug Use</b>	<input type="checkbox"/> <input type="checkbox"/>	Dialysis	<input type="checkbox"/> <input type="checkbox"/>	Neuromuscular Disease	<b>Hematologic</b>
<input type="checkbox"/> <input type="checkbox"/>	Alcohol / Drug	<input type="checkbox"/> <input type="checkbox"/>	Nocturia	<input type="checkbox"/> <input type="checkbox"/>	LOC / Syncope	Sickle Cell
<input type="checkbox"/> <input type="checkbox"/>	Other _____	<input type="checkbox"/> <input type="checkbox"/>	Urinary Sx _____	<input type="checkbox"/> <input type="checkbox"/>	Other _____	Coagulopathy
			Other _____	<input type="checkbox"/> <input type="checkbox"/>	<b>Obstetrics</b>	Hx of Bleeding After
				<input type="checkbox"/> <input type="checkbox"/>	LMP _____	Previous Surgery
				<input type="checkbox"/> <input type="checkbox"/>	Other _____	Accapt Transfusion
						Other _____

**PHYSICAL EXAMINATION**

BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

General Appearance \_\_\_\_\_

HEENT \_\_\_\_\_

Neck \_\_\_\_\_

Heart / Vessels \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

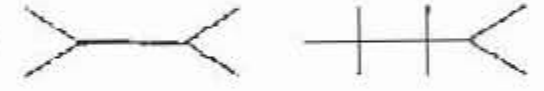
Neurological \_\_\_\_\_

Musculoskeletal \_\_\_\_\_

Genitalia / Rectum \_\_\_\_\_

Specific Exam \_\_\_\_\_

Labs



**ASSESSMENT**

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Signature (Licensed Practitioner) \_\_\_\_\_ Date \_\_\_\_\_

Signature (Anesthesiologist) \_\_\_\_\_ Date \_\_\_\_\_