Memorial Hospital Experience Matters	DATE	PATIENT LABEL
SURGICAL HISTORY & PHYSICAL EXAMINATION		
Age _____ ☐ Male ☐ 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	No	Cardiovascular
☐	☐	MI
☐	☐	Hypertension
☐	☐	Arrhythmia
☐	☐	Angina / CAD
☐	☐	CHF
☐	☐	Valvular Disease
☐	☐	Peripheral Vascular Disease
☐	☐	Past Cardiac Disease
☐	☐	Pacemaker / AICD
☐	☐	CABG / PTCA
☐	☐	Chest Pain
☐	☐	Palpitations
☐	☐	Edema
☐	☐	Other _____

		Drug Use
☐	☐	Alcohol / Drug
☐	☐	Other _____

Yes	No	Pulmonary
☐	☐	Smoking Hx
☐	☐	Asthma
☐	☐	COPD / Emphysema
☐	☐	SOB
☐	☐	Cough
☐	☐	Wheezing
☐	☐	PND / Orthopnea
☐	☐	Sleep Apnea
☐	☐	Other _____

		Renal
☐	☐	Renal Failure / Renal Insufficiency
☐	☐	Dialysis
☐	☐	Nocturia _____
☐	☐	Urinary Sx _____
☐	☐	Other _____

Yes	No	Metabolic
☐	☐	Diabetes
☐	☐	Thyroid
☐	☐	Steroid Use
☐	☐	Obesity
☐	☐	Arthritis
☐	☐	Other _____

		Neuromuscular
☐	☐	Seizure
☐	☐	CVA / TIA
☐	☐	Elevated ICP
☐	☐	Cerebrovascular Disease
☐	☐	Dementia / Depression
☐	☐	Neuromuscular Disease
☐	☐	LOC / Syncope
☐	☐	Other _____

		Obstetrics
☐	☐	LMP _____
☐	☐	Other _____

Yes	No	Gastrointestinal
☐	☐	GE Reflux / Hiatal Hernia
☐	☐	Bowel Obstruction
☐	☐	Hepatitis / Jaundice
☐	☐	Nausea / Vomiting
☐	☐	Diarrhea
☐	☐	Other _____

		Hematologic
☐	☐	Sickle Cell
☐	☐	Coagulopathy
☐	☐	Hx of Bleeding After Previous Surgery
☐	☐	Accept Transfusion
☐	☐	Other _____

PHYSICAL EXAMINATION

BP _____ Temp _____ Pulse _____ Resp _____ HT _____ WT _____

General Appearance _____

HEENT _____

Neck _____

Heart / Vessels _____ Labs

Lungs _____

Abdomen _____

Neurological _____

Musculoskeletal _____

Genitalia / Rectum _____

Specific Exam _____

ASSESSMENT

Signature (Licensed Practitioner) _____ Date _____

Signature (Anesthesiologist) _____ Date _____