

History and Physical Examination



**ALLEGHENY
GENERAL HOSPITAL**
WEST PENN ALLEGHENY HEALTH SYSTEM

Allegheny General Hospital
Pittsburgh, Pennsylvania

IMPRINT PATIENT'S PLATE HERE

Date _____ Procedure Date _____

Surgeon/Attending Physician: _____ PCP: _____

Proposed Procedure: _____ Pre-op Diagnosis: _____

Allergies / Adverse Reactions NKDA / Allergies _____

CC / HPI _____

Condition / Medications (List medications, including dosage, pain medication / herbal / over-the-counter / diet pills)

Condition	Medication	Condition	Medication	Condition	Medication

Family History _____

Past Surgical History _____

Past Medical History / Review of Systems

<p>HEENT <input type="checkbox"/> None</p> <p><input type="checkbox"/> Recent URI</p> <p><input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> Nasal Obstruction</p> <p><input type="checkbox"/> Environmental Allergies</p> <p><input type="checkbox"/> Dysphagia</p> <p><input type="checkbox"/> Hearing Loss: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Hearing Aids</p> <p><input type="checkbox"/> Blind: <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Cataract</p> <p><input type="checkbox"/> Implants</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Dentures</p> <p><input type="checkbox"/> Other _____</p> <p>Pulmonary <input type="checkbox"/> None</p> <p><input type="checkbox"/> Asthma: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Hospitalized <input type="checkbox"/> Steroid Use</p> <p><input type="checkbox"/> Recent Wheezing <input type="checkbox"/> PO Inhaler</p> <p><input type="checkbox"/> COPD: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Cough: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> O₂ at Home</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> DOE / SOB</p> <p><input type="checkbox"/> Other _____</p> <p>Cardiovascular <input type="checkbox"/> None</p> <p><input type="checkbox"/> MI: Site: _____ Date _____</p> <p><input type="checkbox"/> Arrhythmia: Type _____</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Pacemaker <input type="checkbox"/> AICD</p> <p><input type="checkbox"/> Angina: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable</p> <p><input type="checkbox"/> CHF: Date _____ EF _____ %</p> <p><input type="checkbox"/> Valve disease</p> <p><input type="checkbox"/> Moderate <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Peripheral Vascular Disease</p> <p><input type="checkbox"/> Claudication</p> <p><input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Syncope</p> <p><input type="checkbox"/> Carotid Bruit: <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Deep Vein Thrombus</p> <p><input type="checkbox"/> Deep Vein Thrombophlebitis</p> <p><input type="checkbox"/> Pulmonary Embolus</p> <p><input type="checkbox"/> IVC Filter Date _____</p> <p><input type="checkbox"/> Angioplasty/Stent Date _____</p> <p><input type="checkbox"/> Echo: Date _____</p>	<p><input type="checkbox"/> Stress Test/Cardiac Cath</p> <p>Date _____</p> <p><input type="checkbox"/> CABG Date _____</p> <p><input type="checkbox"/> MVR Date _____</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Other _____</p> <p>Activity Level</p> <p><input type="checkbox"/> Bedridden</p> <p><input type="checkbox"/> Assistance with Self-care</p> <p><input type="checkbox"/> <1 Flight of Stairs</p> <p><input type="checkbox"/> 1 to 2 Flights of Stairs</p> <p><input type="checkbox"/> >2 Flights of Stairs</p> <p><input type="checkbox"/> Able to lie flat</p> <p><input type="checkbox"/> Exercise _____</p> <p>Gastrointestinal <input type="checkbox"/> None</p> <p><input type="checkbox"/> GERD / Hiatal Hernia</p> <p><input type="checkbox"/> Bowel Obstruction</p> <p><input type="checkbox"/> Ulcers Site: _____ <input type="checkbox"/> Bleeding</p> <p><input type="checkbox"/> Upper GI Bleed: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Lower GI Bleed: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Hepatitis Type (circle) A B C D</p> <p><input type="checkbox"/> Cirrhosis: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Ascites</p> <p><input type="checkbox"/> Other _____</p> <p>Genitourinary <input type="checkbox"/> None</p> <p><input type="checkbox"/> UTI</p> <p><input type="checkbox"/> Prostate Enlargement <input type="checkbox"/> Obstruction</p> <p><input type="checkbox"/> Hematuria</p> <p><input type="checkbox"/> Voiding Dysfunction</p> <p><input type="checkbox"/> Other _____</p> <p>Renal <input type="checkbox"/> None</p> <p><input type="checkbox"/> Renal Insufficiency: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Dialysis: <input type="checkbox"/> Hemo <input type="checkbox"/> Peritoneal</p> <p><input type="checkbox"/> CKD Stage 1 2 3 4 5 6</p> <p><input type="checkbox"/> AV Fistula Location _____</p> <p><input type="checkbox"/> Calculi Site _____</p> <p><input type="checkbox"/> Other _____</p> <p>Endocrine <input type="checkbox"/> None</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Steroid Usage Date _____</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Adrenal Insufficiency</p> <p><input type="checkbox"/> Polycystic Ovary Syndrome</p> <p><input type="checkbox"/> Dyslipidemia</p> <p><input type="checkbox"/> Other _____</p>	<p>Hematology / Oncology <input type="checkbox"/> None</p> <p><input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Trait</p> <p><input type="checkbox"/> Coagulopathy: <input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Due to Meds <input type="checkbox"/> Type _____</p> <p><input type="checkbox"/> Anemia: <input type="checkbox"/> Chronic <input type="checkbox"/> Acute</p> <p><input type="checkbox"/> Past Transfusion</p> <p><input type="checkbox"/> Refuses Transfusion</p> <p><input type="checkbox"/> Tumor _____</p> <p><input type="checkbox"/> Chemo / Rad Therapy</p> <p><input type="checkbox"/> Other _____</p> <p>Musculoskeletal <input type="checkbox"/> None</p> <p><input type="checkbox"/> Arthritis Site _____</p> <p><input type="checkbox"/> Fractures (recent) Site _____</p> <p><input type="checkbox"/> Back/Neck Problems</p> <p><input type="checkbox"/> Eczema, Psoriasis</p> <p><input type="checkbox"/> Collagen Vascular Disease</p> <p><input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> Other _____</p> <p>Infections <input type="checkbox"/> None</p> <p><input type="checkbox"/> SBE Prophylaxis</p> <p><input type="checkbox"/> HIV: <input type="checkbox"/> Sepsis <input type="checkbox"/> URI</p> <p><input type="checkbox"/> VRE</p> <p><input type="checkbox"/> MRSA: Contact / Resp</p> <p><input type="checkbox"/> Other _____</p> <p>Neurologic <input type="checkbox"/> None</p> <p><input type="checkbox"/> Seizure or <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Normal Pressure Hydrocephalus</p> <p><input type="checkbox"/> Spinal Cord Injury</p> <p><input type="checkbox"/> CVA <input type="checkbox"/> TIA</p> <p><input type="checkbox"/> Embolus <input type="checkbox"/> Thrombosis</p> <p><input type="checkbox"/> Cerebral Palsy</p> <p><input type="checkbox"/> Mental Retardation</p> <p><input type="checkbox"/> Chronic Pain _____</p> <p><input type="checkbox"/> Neuropathy / Paresthesia</p> <p><input type="checkbox"/> Myopathy / Muscular Dystrophy</p> <p><input type="checkbox"/> Other _____</p> <p>Obstetrics/Gyn <input type="checkbox"/> None <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Pre-eclampsia / Eclampsia</p> <p><input type="checkbox"/> Placenta Previa / Abruption</p> <p><input type="checkbox"/> LMP _____ Hcg <input type="checkbox"/> Neg <input type="checkbox"/> Pos</p> <p><input type="checkbox"/> Gravida _____ <input type="checkbox"/> Para _____</p> <p><input type="checkbox"/> Breast Abnormality</p> <p><input type="checkbox"/> Other _____</p>	<p>Organ Transplant <input type="checkbox"/> None</p> <p><input type="checkbox"/> Organ: _____ Date: _____</p> <p><input type="checkbox"/> Immunocompromised</p> <p>Pediatrics <input type="checkbox"/> None <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Prematurity</p> <p><input type="checkbox"/> Congenital Abnormality</p> <p><input type="checkbox"/> Apnea</p> <p><input type="checkbox"/> Passive Smoking</p> <p><input type="checkbox"/> Developmental Delays</p> <p><input type="checkbox"/> Birth Weight _____</p> <p>(children under 8 months)</p> <p><input type="checkbox"/> Other _____</p> <p>Anesthesia Issues <input type="checkbox"/> None</p> <p><input type="checkbox"/> Difficult Airway</p> <p><input type="checkbox"/> By Exam <input type="checkbox"/> By History</p> <p><input type="checkbox"/> TMJ problems</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Stridor / Croup</p> <p><input type="checkbox"/> Malignant Hyperthermia</p> <p><input type="checkbox"/> Family History</p> <p><input type="checkbox"/> Prolonged Emergence</p> <p><input type="checkbox"/> Post-op Nausea / Vomiting</p> <p>Social History <input type="checkbox"/> None</p> <p><input type="checkbox"/> Smoking Hx <input type="checkbox"/> Current ___ppd x ___yrs</p> <p>If quit, month / year _____</p> <p><input type="checkbox"/> Chewing Tobacco Hx</p> <p>If quit, month / year _____</p> <p><input type="checkbox"/> ETOH <input type="checkbox"/> Abuse <input type="checkbox"/> Dependence</p> <p><input type="checkbox"/> Continuous <input type="checkbox"/> Episodic</p> <p><input type="checkbox"/> Remission</p> <p><input type="checkbox"/> Drug Type _____</p> <p><input type="checkbox"/> Abuse <input type="checkbox"/> Dependence</p> <p><input type="checkbox"/> Continuous <input type="checkbox"/> Episodic</p> <p><input type="checkbox"/> Remission</p> <p><input type="checkbox"/> IV Last used _____</p> <p><input type="checkbox"/> Other _____</p> <p>Information taken by: _____</p> <p>Date: _____</p>
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Patient Name _____ Date _____

Physical Examination

General Appearance: _____

Height: _____ Weight: _____ BP: _____ Heart Rate: _____ Resp. Rate: _____ Temp.: _____ SaO₂: _____

Head & Neck: _____

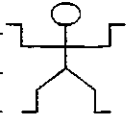
Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Neurologic / Spine: _____



Other Pertinent Exam _____

Impressions _____

Current Medical Treatment Plan

Condition	Treatment

Examiner: _____ Signature: _____ Date & Time: _____

See dictated H&P dated _____ (≤30 days before admission) by Dr. _____ and complete section below.

Update Assessment: Date: _____ Time: _____ The patient was assessed No change in patient status

Change in patient status (specify): _____

_____ Signature _____

Labs/Tests Normal Laboratory Values

•Hgb/Hct/PLT _____ Date _____ •Na+/Cl _____ Date _____ •BUN/CREAT _____ Date _____

•PT/PTT/INR _____ Date _____ •K/Glucose _____ Date _____ •CXR _____ Date _____

•EKG _____ Date _____ •Other _____ Date _____

Pre-Anesthetic Evaluation Department of Anesthesiology

Anesthesia Issues

Last Oral Intake: Solid _____ Liquid _____ Anesthesia Sequelae None Patient Family

•Airway/Dental _____

•Chest _____ •Heart _____

•Neuro/Back _____ •Other _____

Anesthetic Options, Risks and Benefits Discussed/Plan _____

Planned Post-op Care PACU ICU ACC / ASU Other _____

ASA PS 1 2 3 4 5 6 E NPO _____

Examiner: _____ Signature: _____ Date & Time: _____