EXCEL

ORTHOPEDIC SURGERY & RECOVERY
TWIN CITIES ORTHOPEDICS

Preoperative History & Physical

Please fax to 763-302-2705

Dear Provider, (form not to be completed by the patient)
Surgery will be completed in an ambulatory surgery center. We ask that the following labs are completed for our patients within 30 days of surgery:

-CBC
-BMP
-EKG for anyone >65 or has a cardiac hx or cardiac medications 6 months
-A1C within the last three months with diabetes dx

Thank you!

Patient Name:_____ Date of Birth:_____

Surgeon:_____Date of Surgery_____

Date of Exam:_____

PREOP DIAGNOSIS / REASON FOR SURGERY:_____

_____

SURGERY / PROCEDURES INDICATED:_____

_____

HISTORY OF PRESENT ILLNESS: _____

_____

_____

Has a member of your Family or a Partner (now or in the past) intimidated, hurt, manipulated or controlled you in any way?
☐ Yes ☐ No Referral needed: ☐ Yes ☐ No

PAST HISTORY:

Surgical (including any anesthetic problems):_____

_____

Medical: ☐ CAD ☐ HTN ☐ Valvular heart disease ☐ Dysrhythmia ☐ CHF ☐ Pulmonary disease
☐ Other:_____

MEDICATIONS (include herbals and vitamins):

Aspirin / NSAID use in last 10 days: ☐ Yes ☐ No Steroid use in last 10 days: ☐ Yes ☐ No

Plavix use in last 7 days: ☐ Yes ☐ No

Medications	Dose	Frequency	Medications	Dose	Frequency

ALLERGIES: _____ ☐ Latex ☐ Tape **INTOLERANCES:**_____

SOCIAL HISTORY: (☐ tobacco, ☐ alcohol, or ☐ drug use):_____

Health Care Directive: ☐ Yes ☐ No

Nutrition Status:_____

Learning Barriers:_____

FAMILY HISTORY:_____

FH of anesthesia reactions ☐ Yes ☐ No (if Yes, comment):_____ FH of bleeding disorder ☐ Yes ☐ No

REVIEW OF SYSTEMS (any history or symptoms of the following):

Yes	No	Comments if Yes	Yes	No	Comments if Yes
☐	☐	General Appearance:_____	☐	☐	Diabetes/Endocrine:_____
☐	☐	Skin:_____	☐	☐	Cardiovascular:_____
☐	☐	Head:_____	☐	☐	Respiratory:_____
☐	☐	Eyes:_____	☐	☐	GI/Hepatitis:_____
☐	☐	Ears:_____	☐	☐	Urinary:_____
☐	☐	Nose:_____	☐	☐	Neurological:_____
☐	☐	Mouth and Throat:_____	☐	☐	Hematologic:_____
☐	☐	Infectious Disease:_____	☐	☐	Musculoskeletal:_____
☐	☐	Psychological:_____	☐	☐	Genito-reproductive:_____

Preoperative History & Physical

Phone: 952-456-7300

Fax: 763-302-2705

Patient Name:_____

PHYSICAL EXAM:

Height:_____ Weight:_____ BMI:_____ Blood Pressure:_____

Pulse:_____ Respirations:_____ LMP:_____ Women of child bearing age need a pregnancy test:

Results_____.

	Normal	Abnormal - describe		Normal	Abnormal - describe
General Appearance	☐	_____	Heart	☐	_____
Skin	☐	_____	Abdomen	☐	_____
Head	☐	_____	Genitourinary	☐	_____
Eyes	☐	_____	Vaginal	☐	_____
Ears	☐	_____	Rectal	☐	_____
Nose	☐	_____	Musculoskeletal	☐	_____
Mouth and Throat	☐	_____	Lymphatics	☐	_____
Neck	☐	_____	Blood Vessels	☐	_____
Thorax	☐	_____	Neurological	☐	_____
Breasts	☐	_____	Other Findings/Diagnosis:		_____
Lungs	☐	_____			

LAB / RADIOLOGY RESULTS:

Hgb:_____ PLT:_____ INR:_____ BUN/Creat:_____

CXR:_____ (New or unstable cardiopulmonary disease)

Electrolytes: K +_____ (Digoxin or diuretic use, or renal disease)

If Diabetic, Glucose:_____

EKG:_____ (Enclosed copy) (Consider age guidelines: patients ≥ 60 or patients with hypertension, diabetes, peripheral vascular disease, chest pain, CAD if not done in last 6 months)

ECHO:_____ Stress Testing:_____

PFT: FEV_1_____ FVC_____

Other Test Results:_____

IMPRESSION / ACTIVE PROBLEMS:

☐ CAD: Severity/functional status:_____ ☐ Stable ☐ Needs preop evaluation

Most recent evaluation/intervention:_____

☐ HTN: ☐ Well controlled ☐ Other_____

☐ Valvular heart disease (or undefined murmur): Lesions/severity_____ ☐ Stable ☐ Needs preop evaluation

Last Echo:_____

☐ Dysrhythmia ☐ Atrial Fibrillation/Flutter ☐ Rate controlled ☐ Other:_____

☐ History of ventricular dysrhythmia_____

☐ CHF (or history of): Etiology:_____ ☐ Well compensated ☐ Other:_____

Last Echo:_____

☐ Pulmonary disease: ☐ COPD:_____ ☐ Restrictive ☐ Stable ☐ Other:_____

Last PFT:_____

☐ Sleep Apnea History of:_____

Other pertinent diagnoses:_____

_____

PLAN: ☐ Patient's active problems diagnostically and therapeutically optimized for planned procedure.

☐ Other_____

_____

Provider Signature:_____ **Date:**_____ **Time:**_____

Print Provider Name:_____

Clinic Name and Number:_____