HealthEast Care System

☐ Bethesda Hospital ☐ Surgery Center-Maplewood
☐ St. John's Hospital ☐ Hospice
☐ St. Joseph's Hospital ☐ Midway Outpatient
☐ Woodwinds Health Campus
☐ Other _____

SJNE fax: 326-8631
WW fax: 232 0616

Patient Name	DOB

Check Appropriate Box: [ ] Preop H&P [ ] Preop Consult Requesting Physician:

Exam Date: Surgery Date: Surgery Facility:

Scheduled Surgery:

COMPLETE FOR PREOP CONSULTS: _____ is being seen today for Preop Consultation at the request of Dr. _____ for the underlying condition of:

HPI (If consult, address the underlying condition):

Wt _____
HT. _____
BMI _____
LMP _____
BP _____
Pulse _____ /min
Resp _____ /min
O2sat _____ %
@ room air
Temp. _____

Review of Systems (ROS)	Normal	Abnormal (needs explanation)
Constitution		
Eyes		
ENT		
Respiratory		
Breast/Skin		
Cardiovascular		
GI		
Urinary		
Reproductive		
Musculoskeletal		
Neuro		
Endocrine		
Mental Health		
Lymph / Heme		
Remaining ROS neg		

PHYSICAL EXAMINATION

Body Piercings (must remove ALL)		[ ] None [ ] Pt. will remove
Eyes		
ENT		
Neck		
Chest / Breast		
Respiratory		
Cardiovascular		
Abdomen		
Genital / Pelvis		
Liver / Spleen		
Muscular Skeletal Upper Extremities		
Lower Extremities		
Skin		
Neurologic		
Psych/Mental Status		
Lymphatic		
Other Findings		

Past/Current Medical Problems
(i.e. past illnesses, Hx of hepatitis/ significant infections, trauma etc)

Bleeding Disorders [ ] no [ ] yes
Tobacco Use [ ] no [ ] yes

Hospitalizations/Year

Surgeries / Year

Anesthesia Reactions [ ] no [ ] yes

Family History (cardiac, cancer, respiratory etc)
Anesthesia Reactions [ ] no [ ] yes
Bleeding Disorders [ ] no [ ] yes

Do Not Write Below this line – Does not fax completely!

Original: Clinic/Hospital/ Surgery Center Copy: Give to Patient to bring

7925

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EXAM DATE: Page 2 of 2

Social History (Alcohol/ drug use etc)

Allergy (Include: Meds, Dyes, Foods, Iodine, Latex, Tape, other)	Allergic Reactions	Allergy (Include: Meds, Dyes, Foods, Iodine, Latex, Tape, other)	Allergic Reactions
[ ] No allergies	NA		

PROVIDER COMPLETING H&P MUST COMPLETE ALL INFORMATION – PLEASE CLEARLY ADDRESS CURRENT MEDICATION(S)

PATIENT MEDICATION INFORMATION ONLY – NOT PHYSICIAN ORDERS

MEDICATIONS: (Prescription, Over the-counter, Aspirin, Eye drops, Inhalers, Patches, Supplements, Diet pills, Herbals, Vitamins, Homeopathic Therapies, Birth Control etc.)	INDICATIONS FOR MEDICATIONS	Dose	Route	Frequency	Should pt continue or stop meds BEFORE surgery? Need stop date & time	If meds stopped, preop, when do you recommend they restart? Check or write in
[ ] No Current Meds	NA	NA	NA	NA	NA	NA
					[ ] continue [ ] stop	[ ] restart postop
					[ ] continue [ ] stop	[ ] restart postop
					[ ] continue [ ] stop	[ ] restart postop
					[ ] continue [ ] stop	[ ] restart postop
					[ ] continue [ ] stop	[ ] restart postop
					[ ] continue [ ] stop	[ ] restart postop
					[ ] continue [ ] stop	[ ] restart postop

[ ] refer to " Supplemental Medication Summary Sheet" for additional patient medication documentation

Labs/Diagnostic Tests >>Performed/results at : [ ] this Clinic [ ] HML Other: _____

Check if ordered	Results	
____ HGB	_____gm/dl	____EKG [ ] enclosed report & copy of EKG
____ K+	_____mmol/L	(Pt on HBP meds/CVD/Diabetics on Insulin/>60y/o)
____ Hemogram 2	_____in chart	
____ U A	_____in chart	Other tests:
____ Pregnancy Test	_____in chart	

DIAGNOSES / PLAN: NO ORDERS >>>>>> MUST CALL ORDERS IN TO SURGERY FACILITY

Pt. approved for scheduled surgery with _____ anesthesia/ cc. H&P to: Physician Requesting Consult

Post Op Medical Care will be managed by:

PRINT Provider Name (H.E. Mandatory) _____ Date: _____

Provider Signature: _____

Clinic Name: _____ Clinic Phone #: _____ Clinic Fax #: _____

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