Preoperative Assessment Form

Date of preoperative assessment:	Date of planned surgery:

Patient information

Full name:	Gender:	Date of birth:
Age:	Address:	Contact information:

First point of contact

Will this person be escorting you home? Yes No

Name:	Relationship:	Contact information:

Attending surgeon

Name:	Designation:
Hospital/location of surgery:	Planned surgical procedure:

History of present illness

[ ] **All relevant preoperative PMH listed below was reviewed and found to be negative unless specified below.**

Past medical history	Yes	Date	Cardiac history	Yes	Date
CKD stage ______/dialysis			Pulmonary hypertension (latest PAP ________________________)		
TIA/CVA/hemiplegia/ hemparesis/residual deficit ____________________________			Congenital heart disease		
DVT/PE			MI [ ] Yes [ ] No [ ] <30d		
Anemia			PCI stent [ ] Bare [ ] Drug		
Active infection/sepsis			Angina [ ] Unstable [ ] Stable [ ] Severe		
Asthma/COPD			HTN [ ] Yes [ ] No [ ] Controlled		
Chronic respiratory failure on home O_2			CAD (History of abnormal stress test or Q waves on EKG)		

Past medical history	Yes	Date
Cancer		
Chronic steroids		
Cirrhosis		
Coagulopathy/on anticoagulation		
Diabetes Insulin: [ ] Yes [ ] No		
HIV/AIDS		
Chronic hepatitis [ ] B [ ] C [ ] Treated		
Obesity w/ hypoventilation syndrome		
OSA (if yes, is the patient adherent to CPAP)		
STOPBANG		
Others:		

Cardiac history	Yes	Date
Chronic systolic/diastolic CHF [ ] Compensated [ ] Not		
Cardiomyopathy		
Valve disease [ ] Symptomatic [ ] Severe AS, MS, MR		
Arrythmia		
PM/ICD (manufacturer, indication, device settings, when last interrogated)		

For female patients		
Are you currently pregnant?	[ ] Yes	[ ] No
Is there a possibility you may be pregnant?	[ ] Yes	[ ] No

All patients		
Do you have any other health conditions?	[ ] Yes	[ ] No
If yes, write here:		
Prior anesthesia complication?	[ ] Yes	[ ] No
History of difficult intubation:	[ ] Yes	[ ] No
If yes, describe:		

Social history
[ ] ETOH/drinks per week:
[ ] Smoking status, # of pack/years:
[ ] Other substance abuse:
[ ] Counseling provided?
Religious considerations?

Family history:

Allergies/reaction

Past surgical history		
Procedure	**Date**	**Remarks**

Medication	Dose	Frequency	Continue?	
			Yes	No

Review of systems			
System	**Symptoms**	**Negative**	**Positive**
Gen	Weight loss or gain, fatigue, fever or chills, weakness, trouble sleeping		
CVS	Chest pain, irregular heartbeat, SOB, difficulty breathing at night, swollen legs or feet		
Resp	Chronic dry cough, coughing up blood, wheezing or night sweats		
HEENT	Double or blurred vision, loss of hearing, nosebleeds, dentures		
Heme	Bleeding tendency or clotting tendency		
GI	Nausea, vomiting, diarrhea, black stools, abdominal pain		
GU	Difficult urination, burning with urination, blood in the urine		
Vascular	Calf pain with walking, leg cramping		
Musculoskeletal	Muscle or joint pain, stiffness, back pain, redness of joints, swelling of joints, trauma		
Neuro	Headache, dizziness, fainting, LOC, memory loss		
Psych	Nervousness, stress, depression, memory loss		
Other			

Physical exam	
Blood pressure:	**Height:**
Heart rate:	**Weight:**
Temperature:	**BMI:**
Respiration rate:	**Oxygen saturation:**

Physical exam	
Check for normal exam, indicate abnormal findings and describe.	
General	[ ] Alert and oriented to person, place and time
	[ ] No abnormality detected
ENT	[ ] Throat clear
Neck	[ ] No bruits
	[ ] No jugular vein distention
CV	[ ] Regular rate and rhythm
	[ ] No murmurs, rubs, gallops
Lungs	[ ] CTA bilatera
	[ ] No wheezes or rhonchi
	[ ] Normal respiratory effort
Abdomen	[ ] Soft
	[ ] Non-tender/non-distended
Extremities	[ ] No clubbing, cyanosis, or edema
	[ ] Normal pulses
Neuro	[ ] Normal and equal strength
Other	

Test	Date	Results
CXR		
EKG		
Echo		
Stress test		
Cardiac catheterization		
Other studies		

Surgical risk for planned procedure	
Risk of planned surgical procedure [ ] Low [ ] Intermediate [ ] High	[ ] **High risk cardiac conditions** (Unstable angina, decompensated CHF, significant arrhythmia, or significant valvular disease)

Cardiac risk assessment	
RCRI risk score: ___________ (High-risk surgical procedure, ischemic heart disease, heart failure, CVA/TIA, DM on insulin, chronic renal insufficiency)	
[ ] **The patient has a** ([ ] low / [ ] elevated) **risk of a major cardiovascular event.**	**If elevated, please specify patient's metabolic equivalents (METs)**: [ ] >4 [ ] <4 [ ] Unable to assess

Non-cardiac risk assessment		
Further testing indicated: [ ] Yes [ ] No	**Further consults indicated:** [ ] Yes [ ] No	
Overall medical risk for surgery		
[ ] **Optimized**	[ ] **Not optimized**	[ ] **Optimized pending:**
Recommendations		
Practitioner name (printed):	**Date:**	**Time:**
Practitioner signature:	**Contact number:**	
[ ] ***I have interviewed and examined the patient. I have confirmed the plan of care with the Resident/NP/PA.***		
Attending signature:	**Date:**	**Time:**
Print name:		
[ ] **I have reviewed the pre-operative medical assessment and acknowledge its findings. I have discussed the alternative treatment options and the potential risks and anticipated benefits of the planned procedure with the patient and/or his/her family in light of the findings. All questions have been answered.**		
Reviewed by:		
Attending surgeon's name:	**Signature:**	**Date:**