HSS

Name: _____

HSS MRN: _____

DOB: _____

Type of Surgery: _____

Date of Planned Surgery: _____

History & Physical

Chief Complaint: _____

HPI: _____

Past Medical History – please be as specific as possible:

Medical Device

- ☐ AICD implant
- ☐ Baclofen pump implant
- ☐ Bladder stimulator implant
- ☐ Chemo pump implant
- ☐ Deep brain stimulator implant
- ☐ Defibrillator implant
- ☐ Insulin pump
- ☐ Loop recorder implant
- ☐ Neurostimulator implant
- ☐ Pacemaker implant
- ☐ Pain pump implant
- ☐ Sleep apnea implant
- ☐ VP shunt implant
- ☐ Other implant (discuss with nurse)

Past Surgical History – please be as specific as possible:

Medications:

Allergies / Intolerances:

Drug	Associated Reaction

Do you have a Penicillin (or antibiotic related) allergy? ☐ Yes ☐ No

What type of reaction do you have? (please check all that apply)

- ☐ Anaphylaxis
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Throat Tightness
- ☐ Swelling of Face
- ☐ Hives
- ☐ Rash (type): _____
- ☐ Nausea
- ☐ Headache
- ☐ Diarrhea
- ☐ Vaginal Itching
- ☐ Other, please describe _____

Social History

- **Tobacco** ☐ Yes ☐ No If yes, how much? _____
- **Alcohol** ☐ Yes ☐ No If yes _____ drinks/week
- **Other Drugs** ☐ Yes ☐ No If yes, please specify: _____

Family History

- **Bleeding History** ☐ Yes ☐ No
- **Anesthesia Problems?** ☐ Yes ☐ No
- **If yes**, what was the complication associated with anesthesia?

Review of Systems:

Obstructive Sleep Apnea

- **STOP-Bang Score:** _____ (see STOP-Bang Sleep Apnea Questionnaire)
- **Diagnosed Sleep Apnea?** ☐ Yes ☐ No If yes, uses CPAP? ☐ Yes ☐ No
- If yes, what is the CPAP Setting: _____

Physical Exam:

- **Vital Signs:** P_____ BP _____ R _____ Wt _____ HT_____ Pulse Ox _____
- **Skin:** _____ **Ext:** _____
- **HEENT:** _____ **Abd:** _____ **Neuro:** _____
- **Lungs:** Normal Breath? ☐ Yes ☐ No If no, explain _____
- **Cardiovascular: Normal Rhythm?** ☐ Yes ☐ No If no, explain _____
  Murmur ☐ Yes ☐ No If yes, explain _____

Results:

Impression:

Medically Optimized for Surgery? ☐ Yes ☐ No

Plan: _____

1. Medications to take the morning of surgery: _____
2. Medications to stop before surgery: _____
3. If yes, when should these medications be stopped: _____
4. Recommendations: _____

Signature: _____ **Print Name:** _____

Date: _____ **Phone Number:** _____