PLEASE FAX COMPLETED DOCUMENTS TO (212) 774-2798

HOSPITAL FOR SPECIAL SURGERY

History & Physical

Name:
HSS MRN:
DOB:
Type of Surgery:
Date of Planned Surgery:

Chief Complaint:

HPI:

Past Medical History:

Past Surgical History:

Medications:

Allergies:

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

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

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. Recommendations:

Signature:_____ Print Name: _____
Date:_____ Phone Number: _____