HSS HOSPITAL FOR **SPECIAL SURGERY**

Date of exam: ______
Name: ______
MRN: ______
DOB: ______

Chief Complaint:
Preoperative Assessment for Planned Surgery ______

HPI: ______

Past Medical History:

Past Surgical History:

Medications:

Allergies:

Social History

- **Tobacco** ☐ Yes ☐ No
- **Alcohol** ☐ Yes If yes, how much? ______ ☐ No
- **Other Drugs** ☐ Yes ☐ No

HOSPITAL FOR
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Family History:

- Bleeding History ☐ Yes ☐ No
- Anesthesia problems ☐ Yes ☐ No

Review of Systems:

- Stop Bang Score ______ or Dx Sleep Apnea ______ . If Sleep Apnea, uses CPAP ☐ Yes ☐ No

Physical Exam:

Vital Signs: • P ______ •BP ______ •R ______ •Wt ______ •HT ______ •Pulse Ox ______

- Skin: ______
- HEENT: ______
- Lungs: ______
- Cor: ______
- Abd: ______
- Ext: ______
- Neuro: ______

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: ______