Lenox Hill Hospital
Northwell Health®
100 East 77th Street, New York, NY 10075-1850
210 East 64th Street, New York, NY 10065-7471

PRE-OPERATIVE HISTORY AND PHYSICAL

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PHONE : 646-665-6784
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DATE OF SURGERY: _____ PATIENT NAME: _____ D.O.B.: _____

SURGICAL PROCEDURE: _____

HISTORY OF PRESENT ILLNESS: _____

PAST MEDICAL Hx:

	Yes	No		Yes	No		Yes	No		Yes	No
Hypertension	☐	☐	Myocardial Infarction	☐	☐	Pulmonary Disease	☐	☐	Malignancy	☐	☐
Diabetes	☐	☐	Coronary Artery Disease	☐	☐	Hepatic Disease	☐	☐	Blood clots	☐	☐
Dyslipidemia	☐	☐	Cardiac Arrhythmia	☐	☐	Thyroid Disease	☐	☐	Bleeding Disorder	☐	☐
Stroke/TIA	☐	☐	Obstructive Sleep Apnea	☐	☐	Renal Disease	☐	☐	Blood Transfusions	☐	☐

Other/Explanation for Positive History: _____

PAST SURGICAL Hx: _____

List of medications including prescriptions, herbal, supplements, birth control, and over-the-counter medications.

Medication Name	Dose	Route	Frequency	Last Dose	Reconciliation	
					Continue	Stop
					Continue	Stop
					Continue	Stop
					Continue	Stop
					Continue	Stop
					Continue	Stop
					Continue	Stop
					Continue	Stop

☐ Not on any medication ☐ Patient's own medication list attached ☐ Outpatient Medication Reconciliation form attached

REVIEW OF SYSTEMS:

	WNL	Positive (check if applicable)
Constitutional	☐	☐ Anorexia ☐ Fatigue ☐ Fever ☐ Weight loss
Cardiovascular	☐	☐ Angina ☐ DOE ☐ Orthopnea ☐ Edema ☐ Palpitations ☐ Syncope
Respiratory	☐	☐ Cough ☐ Dyspnea ☐ Pleuritic chest pain ☐ Other _____
Gastrointestinal	☐	☐ Stomatitis ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
Genitourinary	☐	☐ Dysuria ☐ Frequency ☐ Incontinence ☐ Hematuria ☐ Impotence
Neurologic	☐	☐ Paresthesia ☐ Dysesthesia ☐ Headache ☐ Seizure ☐ Dysphagia
Skin	☐	☐ Rash ☐ Ulcers ☐ Other _____
Hemorrhage	☐	☐ Easy bruising ☐ Epistaxis ☐ Hemoptysis ☐ Hematochezia ☐ Melena
Endocrine	☐	☐ Polyuria ☐ Polydipsia ☐ Heat/Cold Intolerance
Psychiatric	☐	☐ Depression ☐ Anxiety ☐ Hallucinations ☐ Sexual dysfunction
Musculoskeletal	☐	☐ Joint pain ☐ Back pain
Eyes/Ears	☐	☐ Decreased vision ☐ Decreased hearing ☐ Tinnitus

☐ Other _____

ALLERGIES: _____

History of anesthesia reaction? ☐ Y ☐ N

FAMILY Hx: _____

SOCIAL Hx:

Tobacco _____

Alcohol _____

Drugs _____

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PATIENT NAME: _____ DOB: _____

Advance Directive: ☐ Yes ☐ No _____ Health Care Proxy: ☐ Yes ☐ No _____

OB/GYN HISTORY (N/A ☐): Colonoscopy: _____ ☐ counseled DRE/PSA: _____ ☐ counseled

Date of LMP: _____ Age of Menopause: _____ Gravida: _____ Para: _____ Miscarriage(s): _____ Abortion(s): _____

Age of Menarche: _____ Age at First Pregnancy: _____ Age at Last Pregnancy: _____ IUD Implant: ☐ Yes ☐ No _____

Use of Oral Contraceptives: ☐ Yes ☐ No Age began oral contraceptives: _____ Duration: _____

Mammogram: ☐ Yes ☐ No _____ ☐ counseled PAP smear/Pelvic exam: ☐ Yes ☐ No _____ ☐ counseled

PHYSICAL EXAM

Height:	Weight:	BP:	HR:	T:	RR:	SpO2: RA ☐	Pain (0-10):	BMI:

WNL - if not, describe abnormal findings

General ☐ _____
HEENT ☐ _____
Neck ☐ _____
Cardio ☐ _____
Chest/Lung ☐ _____
Abdomen ☐ _____
Extremities ☐ _____
Neurologic ☐ _____
Lymph ☐ _____
Skin ☐ _____
Breasts ☐ _____
Deferred ☐
GU/Rectal ☐ _____
Deferred ☐
Other _____

RESULTS

	NL	ABNL
CHEM	☐	☐
CBC	☐	☐
PT/PTT	☐	☐
UA	☐	☐
Other	☐	☐
EKG	☐	☐
ECHO	☐	☐
Stress Test	☐	☐
CXR	☐	☐

☐ T&S
☐ HCG

Other (i.e. Sleep Study, PFT, MRI, CT, US, Labs, etc.)

_____
_____

☐ Pacemaker ☐ Defibrillator ☐ Loop Recorder
Device Mfr _____
Device Serial # _____

DIAGNOSIS: _____

Patient is medically optimized for the proposed surgery? ☐ Yes ☐ No _____

Examining Provider: _____ Lic. #: _____ Provider stamp
Address: _____
Phone: _____ Fax: _____
Provider Signature: _____
Date/Time: _____

SURGEON ASSESSMENT/PLANNED PROCEDURE:

FOR AMBULATORY/SDA SURGICAL/INVASIVE PROCEDURES (to be completed day of procedure): The patient has been examined and the History and Physical has been reviewed. There are no significant changes in the patient's condition unless noted below.

Signature: MD/DO/NP/PA (House Physician, or Resident for podiatry or dental cases)
Print Name _____ MD/DO/NP/PA Date/Time _____

For Podiatry and Dental patients only: I have reviewed the H&P including the update.
Signature _____ MD/DO/NP/PA Date/Time _____

PRINT RESET