BETH ISRAEL MEDICAL CENTER

060

PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

6812 FL
OFFICE DEPOT
PROOF 1
5/29/12

Surgical Procedure: _____

History of Present Illness:

Past Medical History	Yes (mm/yy)	No
CVA: Hemorrhagic	○	○
Ischemic	○	○
TIA	○	○
DVT	○	○
PE	○	○
Active Infection	○	○
Anemia	○	○
Asthma / COPD	○	○
Cancer	○	○
Chronic Steroid Use	○	○
Cirrhosis	○	○
Coagulopathy	○	○
Diabetes	○	○
Hepatitis B or C	○	○
HIV	○	○
Obesity	○	○
OSA	○	○
Pulmonary HTN	○	○
Renal Disease	○	○
Other	○	○

Cardiac History	Yes (mm/yy)	No
MI	○	○
Angioplasty	○	○
Stent: BMS	○	○
DES	○	○
Hypertension	○	○
CAD	○	○
Angina: Unstable	○	○
Stable Mild (Class I or II)	○	○
Severe (Class III or IV)	○	○
Congestive Heart Failure	○	○
Congenital Heart Disease	○	○
Valve Disease: Severe AS	○	○
Symptomatic MS	○	○
Other	○	○
Arrhythmia	○	○
PPM/AICD implant If yes, model _____	○	○
METS < 4 (e.g., unable to walk up 1 flight of stairs) ☐ Unable to assess	○	○

Allergies ☐ NKDA

Social History

☐ Alcohol

☐ Drugs

☐ Tobacco (ppy ___)

☐ Jehovah's Witness

☐ Other

Prior anesthesia complication?

☐ Yes ☐ No

If yes, describe:

Past Surgical History	Yes (mm/yy)	No
Peripheral Vasc. Surgery	○	○
Aortic Surgery	○	○
Major Vascular Surgery	○	○
Other:	○	○

Other Relevant History

Pregnant: ☐ Yes ☐ No

Family Hx:

Other:

Medications	Dose	Continue? Yes	No
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○

61315 (05/12)

BETH ISRAEL MEDICAL CENTER

PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

Review of Systems: (Click all that apply)

System	Symptoms	Negative
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	☐
Neuro	headache, dizziness, fainting, LOC, memory loss	☐
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	☐
Other		☐

Physical Exam

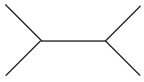
BP _____ HR _____ T _____ RR _____ HT _____ WT _____ Pain Score _____

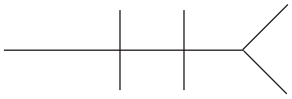
Check for normal exam, indicate abnormal findings and describe

General	☐ A&O x 3 ☐ NAD
ENT	☐ throat clear
Neck	☐ no bruits ☐ no JVD
CV	☐ RRR ☐ no murmurs, rubs, gallops
Lungs	☐ CTA bilat. ☐ no wheezes or rhonchi ☐ nl resp. effort
Abd	☐ soft ☐ ND/NT
Ext	☐ no clubbing, cyanosis, or edema ☐ nl pulses
Neuro	☐ nl and equal strength
Other	

Test	Date	Results
CXR		
EKG		
Echo		
Stress Test		
Cardiac Cath		
Other Studies		

Labs





BETH ISRAEL MEDICAL CENTER

060

PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

Surgery Specific Risk: ☐ Low ☐ Intermediate ☐ High

Severe cardiac conditions: ☐ Yes ☐ No (Unstable angina, decompensated CHF, significant arrhythmia or significant valvular disease)

Recommendations

RCRI Score: _____ (High-risk surgical procedure, ischemic heart disease, heart failure, CVA/TIA, DM, on Insulin chronic renal insufficiency)

# RCRI Risk Factors	Rate of Cardiac Death, Non-Fatal MI, and Non-Fatal Cardiac Arrest
None	LOW
1 - 2	INTERMEDIATE
3 or more	HIGH

This patient is at ☐ Low ☐ Intermediate ☐ High risk for a cardiac complication

Further testing indicated: ☐ Yes ☐ No

Further consults indicated: ☐ Yes ☐ No

Cardiac Recommendation and Medication Management: *(address use of beta-blockers, ACEI, diuretics and statins)* ☐ NA

Other Recommendations (list all relevant diagnoses and medications):

1. DM *(address use of insulin and oral DM meds)* ☐ NA

2. Pulmonary ☐ NA

3. Anticoagulation *(address use of Clopidogrel, ASA, Enoxaparin, etc.)* ☐ NA

4. ID *(address antibiotic use)* ☐ NA

5. Venous Thromboembolism (VTE) Prophylaxis: ☐ NA

6. Other *(address sedatives, NSAIDs, etc.)* ☐ NA

Attending Physician Note

PGY/NP/PA Name (printed) _____ Date _____ Time _____

PGY/NP/PA Signature _____ Contact #_____

Attending Signature _____ Date _____ Time _____

☐ *I have interviewed and examined the patient. I have confirmed the plan of care with the resident.*

Discussed with primary surgical team (name/rank) _____ Date _____ Time _____

Print Name _____

Reviewed by: Attending Surgeon's Signature _____ Date _____ Time _____

Print Name _____

PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

Progress Notes