



**HISTORY, PHYSICAL AND CARDIAC
RISK ASSESSMENT**

217/525-5623 Scheduling Office 217/757-6018 Scheduling Fax

Fax all pre-admission information to 217/757-6018

Tracking # _____ Issued by _____

Name of patient: _____ DOB: _____

Reason for admission: _____ Today's date: _____

Primary care physician: _____

Proposed surgery date: _____ Surgeon: _____

Presenting complaints / reason for surgery _____

Prior Surgeries – List procedure, date, reason for surgery, and complications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Major Medical Problems with ongoing treatment or significant past medical problems. PLEASE GIVE DETAILED INFORMATION.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Medications			Allergies or Adverse Reactions to Medication		
Name	Dose	Frequency	Name		Reaction
			1		
			2		
			3		
			4		
			5		
			6	Anesthetic Jaundice Y N	Malignant hyperthermia Y N
			Family History		
			Bleeding tendencies: Y N Thrombophilia: Y N		
			Other:		
			Social History Occupation:		
			Smoking – current smoker Y N Total pack years –		
			Alcohol use or substance usage –		

Identification of Bleeding Tendencies – does the patient have a personal or family history of:

Excessive nose bleeds? Y N Frequent or easy bruising? Y N Spontaneous joint hemorrhage? Y N

Functional Status / Excellent = > 10 METS Competitive sports, aerobics, jogging, swimming, cycling

Metabolic Equivalents: Intermediate = 4 – 10 METS Climb 1 flight of steps, walk up a hill, short run, walk a mile in 15 minutes

 Poor = < 4 METS Unable to meet criteria for Excellent or Intermediate

In patients unable to meet a 4-Met demand, cardiac and long-term risks are increased: consider a stress test pre-operatively if patient is having an intermediate or high risk procedure.



REVIEW OF SYSTEMS (ROS)

Constitutional Symptoms (e.g., fever, weight loss) Neg or _____

Eye <input type="checkbox"/> Neg or _____	Skin/Breast <input type="checkbox"/> Neg or _____
CV <input type="checkbox"/> Neg or _____	Neuro <input type="checkbox"/> Neg or _____
RESP <input type="checkbox"/> Neg or _____	Psych <input type="checkbox"/> Neg or _____
GI <input type="checkbox"/> Neg or _____	Endo <input type="checkbox"/> Neg or _____
GU <input type="checkbox"/> Neg or _____	Hem <input type="checkbox"/> Neg or _____
MSK <input type="checkbox"/> Neg or _____	ENT <input type="checkbox"/> Neg or _____

PHYSICAL EXAMINATION

VITAL SIGNS

General Appearance _____	Ht _____
Cardiovascular _____	Wt _____
Lungs and Thorax _____	BMI _____
HEENT _____	BP - R _____
Neck _____	BP - L _____
Abdomen _____	Pulse _____
Genitourinary _____	RR _____
Extremities _____	Rest Sa O ₂ _____
Mental Status _____	Exer Sa O ₂ _____
Neurological _____	Temp _____

Attach copies of any recent significant studies: echo, stress test, PFT's, etc.

NOTE: This is not an order sheet. (Please use Physician Order Sheet to initiate orders)

Pager # _____	Printed Name _____	Signature _____	Date _____	Time _____
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Complete the following information if updating an H&P that was completed within the last 30 days.

I have examined this patient, reviewed the H&P, and there are:

no changes to the patient's condition since the H&P was completed.

the following updates to the H&P: _____

Signature _____ Date _____ Time _____

Formulation of Risk Assessment and Plan for Surgery Patients

- Surgery specific risk** Low Intermediate High Revised Cardiac Risk Index Score _____
- Beta blockers** to be started now with _____ contraindicated
 to be continued as _____ not indicated
- DVT Prophylaxis** not indicated Lovenox 40 mg Subcu Daily
 covered under order set or care map Arixtra 2.5 mg Subcu Daily
 unfractionated Heparin 5000 units Subcu every 8 hours Other: _____
 unfractionated Heparin 5000 units Subcu every 12 hours
- Antibiotic Prophylaxis** _____
- _____
- _____
- _____

I will follow this patient post-op for beta blocker YES NO or I designate Dr. _____ to follow for me.