Reset Form

North Shore LIJ Lenox Hill Hospital

FORM D
PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

Please fax all clearance paperwork to (646) 665-6791
Surgeon: PETER MCCANN, MD
200 WEST 13TH STREET 6TH FLOOR
New York, NY 10011
PHONE: 646-665-6784

DATE OF SURGERY: _____ PATIENT NAME: ANTHONY LOSARDO D.O.B.: 09/10/1949

PLANNED PROCEDURE: _____

History of Present Illness: _____

Past Medical History:

	Yes	No		Yes	No		Yes	No		Yes	No
Hypertension	☐	☐	Angina	☐	☐	Liver Disease	☐	☐	Blood clots	☐	☐
Diabetes	☐	☐	Stroke/TIA	☐	☐	Thyroid disease	☐	☐	Bleeding problems	☐	☐
Myocardial Infarction	☐	☐	Lung disease	☐	☐	Kidney Disease	☐	☐	Blood transfusions	☐	☐

Other/Explanation for Positive History: _____

Past Surgical History: _____

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

Allergies: _____

History of anesthesia reaction: ☐ Yes ☐ No _____

Family History: _____

Social History: Tobacco _____ Alcohol _____

Drugs _____ Other _____

Review of Systems:	Neg	Positive (Check if positive)
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 ☐ Dysphagia
Genitourinary	☐	☐ Dysuria ☐ Frequency ☐ Incontinence ☐ Hematuria ☐ Impotence
Neurologic	☐	☐ Paresthesia ☐ Dysesthesia ☐ Headache ☐ Seizure
Skin	☐	☐ Rash ☐ Ulcers ☐ Other_____
Hemorrhage	☐	☐ Easy bruising ☐ Epistaxis ☐ Hemoptysis ☐ Hematochezia ☐ Melena
Endocrine	☐	☐ Polyuria ☐ Polydipsia ☐ Heat/Cold Intolerance
Psychiatric	☐	☐ Depression ☐ Hallucinations ☐ Sexual dysfunction
Musculoskeletal	☐	☐ Joint pain ☐ Back pain
Eyes/Ears	☐	☐ Decreased hearing ☐ Decreased vision

☐ Other _____

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Patient Name: ANTHONY LOSARDO DOB: 09/10/1949 MR #: _____ Acct #: _____

OB/GYN History (Not Applicable ☐): Date of last colonoscopy: _____ ☐ Pt counseled Date of last DRE: _____ ☐ Pt counseled

Age of menarche: _____ Date of LMP: _____ Age of Menopause: _____ Gravida: _____

Para: _____ Miscarriage(s): _____ Abortion(s): _____

Age at First Pregnancy: _____ Age at Last Pregnancy: _____

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

Date of last mammogram: _____ ☐ Pt counseled Date of last PAP smear: _____ ☐ Pt counseled

PHYSICAL EXAMINATION

Height:	Weight:	BP:	P:	T:	R:	Pain (0-10):	BMI:	O_2 Sat:

	WNL	if not: Explanation
General	☐	
Skin	☐	
Neck	☐	
HEENT	☐	
Cardio	☐	
Chest/Lung	☐	
Abdominal	☐	
Ext	☐	
Neurologic	☐	
Nodes	☐	
Breasts	☐	
Refused ☐	☐	
Rectal/Genital/Pelvic	☐	
Refused ☐	☐	

Other (Specify) _____

Significant Labs/X-rays/Exam Diagram

Labs	NL	ABNL
CBC	☐	☐
CHEM	☐	☐
PT/PTT	☐	☐
UA	☐	☐
Other	☐	☐
CXR	☐	☐
EKG	☐	☐ ☐HCG
Other (i.e. Echo, Stress test, PFTs, CT Scan, Labs, Endoscopy, Etc.)	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐

Manufacturer/Brand: _____

DIAGNOSIS: _____

Has the patient been medically optimized for the proposed surgery? ☐ Yes ☐ No _____

Examining Provider: _____ Lic. #: _____ Address: _____ Phone: _____ Fax: _____

MD Signature: _____ MD Stamp:

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/PA (NP, 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: _____

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ADMISSION MEDICATION RECONCILIATION FORM

Allergies/Description of Reaction (include Food): ☐ No Known Drug Allergies ☐ No Known Food Allergies

_____

_____

☐ **Not on any Medication prior to Admission**

Patient Pregnant? ☐ Yes ☐ No **Breastfeeding?** ☐ Yes ☐ No

Source of Medication List: *(Check all used)*

☐ Patient's own medication list ☐ Patient/Family recall ☐ No Historian ☐ Physician List ☐ Pharmacy _____

☐ Previous discharge paperwork ☐ Medication Administration Record from facility*See Attached ☐ Other _____

Medications crossed referenced with: ☐ ED Med List ☐ Outpatient/Ambulatory List

List all medications including prescriptions, herbal, supplements, birth control, over-the counter medications, and recent vaccinations.

Medication	Dose	Route	Frequency	Last Dose Date / Time	Continue on Admission
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change
					☐YES ☐NO ☐Dose Change

***Admitting RN - If a discrepancy is noted please fill out an Addendum Medication Reconciliation Form and notify LIP*

Physician/PA/NP Obtaining Medication History upon Admission: _____ Date/Time: _____

RN Confirming Medication History: _____ Date/Time: _____

Form & Attachments faxed to pharmacy (FAX # 4-6476) by: _____ Date/Time: _____

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PRE-OPERATIVE TESTING - PHYSICIAN GUIDELINES

The following list does not preclude request for tests if deemed appropriate by the surgeon. Provided there is no change in the patients condition that warrants repeat testing, diagnostic tests are valid as follows:

Chest X-rays are acceptable for up to 12 months EKG results for up to 60 days	Laboratory results up to 30 days except Pregnancy Test Type and Crossmatch up to 3 days	If transfusion or pregnancy within 3 months, Type and Crossmatch valid for 72 hours

PRETESTING ORDERS (The appropriate items will necessitate the ordering of tests that appear in the parentheses.)

Condition

- Cardiovascular Disease or High Risk for CV Disease (Hgb, Na, K, Cl, CO2, Bun/Creat, EKG, Chest X-Ray)
- Pulmonary disease (CBC, Chest X-Ray, EKG)
- Malignancy - (CBC, Platelet Count, PT/PTT, Na, K, Cl, CO2, Bun/Creat, LFT, EKG, Chest X-Ray)
- Bleeding Disorder (Hgb, Platelet Count, PT/PTT)
- Smoking > 20 pack years (Hgb, Chest X-ray, EKG)
- Cardiac Surgery/Interventional/Vascular Surgery (CBC, EKG, SMA2O, CPK, PT/PTT, Type & Crossmatch, Magnesium, Fibrinogen, Chest X-ray, PA Lateral)
- Diabetes (Chem-7, EKG)
- Renal Disease (Hgb, Na, K, Cl, CO2, Bun/Creat, EKG)
- Hepatobiliary Disease (PT/PTT, Chem-7, Liver Function)

Medication Use

- Diuretic use (CBC, Na, K, Cl, CO2, Bun/Creat, EKG)
- Digoxin use (CBC, Na, K, Cl, CO2, Bun/Creat, EKG)
- Steroid use (CBC, Chem-7)
- Anticoagulants (Hgb, Platelet count, PT/PTT)

Other

- Urinalysis/Urine Culture and Screen
- Type & Screen
- Chest X-ray, PA & lateral
- Expected blood loss of 2 or more units (Hgb,Type and crossmatch)
- Male > 45 yr. Or Female > 50 yr. (EKG)
- If LMP < or = to 1 year (Pregnancy Test)
- Thyroid Function test
- Tumor

Assess for Day of Procedure:

☐ HCG

☐ K+

☐ X ray's