LenoxHill Hospital

☐ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to 866-219-5545

☐ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to 866-231-1027

FORM D
PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

DATE OF SURGERY:_____ PATIENT NAME:_____ D.O.B.:_____

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_____

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER THE COUNTER AND HERBAL MEDICATIONS.

Medication Name	Dose (mg, mcg)	Route (PO, GT, SC, IV)	Frequency

*If more space is required continue on progress note

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		

Allergies_____

History of anesthesia reaction: ☐ Y ☐ N

Family History_____

Social History

Tobacco_____

Alcohol_____

Drugs_____

Other_____

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FORM D
PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

Patient Name:_____ DOB:_____ MR #:_____ Acct #:_____

OB/GYN History (Not Applicable ☐):

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_____

Mammogram ☐ Yes ☐ No _____ PAP Smear ☐ Yes ☐ No _____

PHYSICAL EXAMINATION

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

	NL	ABNL	Explanation
General	☐	☐	
Skin	☐	☐	
Neck	☐	☐	
HEENT	☐	☐	
Cardio	☐	☐	
Chest/Lung	☐	☐	
Abdominal	☐	☐	
Ext	☐	☐	
Neurologic	☐	☐	
Nodes	☐	☐	
Breasts	☐	☐	
Deferred ☐	☐	☐	
Rectal/Genital/Pelvic	☐	☐	
Deferred ☐	☐	☐	
Other (Specify)			

Significant Labs/X-rays/Exam Diagram

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

DIAGNOSIS _____

No medical contraindications to proposed surgery ☐ Yes ☐ No_____

Examining Provider_____ Lic. #_____ Address_____ Phone_____ Fax_____

MD Stamp

MD Signature: _____ Date: _____

SURGEON ASSESSMENT / PLANNED PROCEDURE

_____

_____

_____

Surgeon Signature _____ Date _____

☐ I certify that I have re-evaluated this patient and there has been no significant change in his/her clinical condition since the above examination.
☐ I certify that I have re-evaluated this patient and there is a change in his/her clinical condition. See Progress Note.

Attending Physician Signature:_____ Date:_____