

Preoperative History & Physical Examination Form

Attach Patient ID Sticker here

Patient Name: _____ Date: _____

Date of Birth: _____ Diagnosis: _____

Proposed Surgical Procedure: _____

Surgeon: _____ Date of Surgery: _____

PAST MEDICAL HISTORY: _____

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Medication	Dosage	Frequency

ALLERGIES: _____

PAST SURGICAL HISTORY

Date	Surgery	Hospital Name	Complications

SOCIAL HISTORY: Smoking: _____ Alcohol: _____ Caffeine: _____

REVIEW OF SYSTEMS Check box if applicable.

Cardiovascular None

- Hypertension
- Angina/chest pain
- MI/CAD
- Arrhythmia/palpitations
- CHF
- Valve disease
- Peripheral vascular disease
- Pacemaker/AICD
- Cardiac surgery
- Coronary stents
- Poor exercise tolerance

Hematologic None

- Sickle cell disease/trait
- Coagulopathy
- Transfusion
- Accepts transfusion
- Anemia
- Cancer
- Chemotherapy

GI/Renal/Endocrine None

- Thyroid disease
- Diabetes I or II
- Obesity
- Heartburn/reflux
- Hepatitis
- Renal insufficiency
- Recent steroid use
- Nausea/vomiting
- Urinary tract infection

Pulmonary None

- Asthma
- Smoking history
- COPD/emphysema
- Sleep apnea
- SOB
- Cough/productive cough
- Wheezing
- PND/orthopnea
- Tuberculosis

Neurologic/MS None

- TIA or stroke
- Seizures
- Neuromuscular disease
- Cerebrovascular disease
- Arthritis
- Dementia/Alzheimer's
- Elevated ICP
- Loss of consciousness
- Back problems
- Muscular dystrophy
- Paralysis
- Syncope

Anesthesia None

- Family history of problems
- Previous anesthesia complications

GYN

LMP: _____
 Tubal ligation

Pediatrics

- Recent URI/Illness
- Prematurity
- Congenital Anomaly
- Apnea

Comment on positives or symptoms not listed:



Rubin Institute for
Advanced Orthopedics

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PHYSICAL EXAM

Sex	Race	Age	Height	Weight (KG)	BP	Pulse	Resp	Temp

General appearance: _____

HEENT PERRLA EOMI No Lymphadenopathy No JVD O/P WNL Thyroid WNL TM WNL

Abnormal: _____

Cardiovascular RRR S1S2 S3 S4

Abnormal: _____

Pulmonary Lungs CTA B/L

Abnormal: _____

GI Abd Benign - Normoactive BS No Hepatosplenomegaly

Abnormal: _____

Extremities No Clubbing No Cyanosis No Edema

Abnormal: _____

Musculoskeletal NML Muscle Tone NML Strength

Abnormal: _____

Neurological CN II-XII intact NML Mood

Abnormal: _____

Genitalia/Rectum Deferred No masses Heme negative

Abnormal: _____

ASSESSMENT: _____

The surgery proposed for this patient is low / intermediate / high risk.

The patient represents low / intermediate / high risk of cardiac mortality because of minor / intermediate / major clinical predictors. _____

PLAN: Further testing for this patient **IS NOT** recommended. The patient may proceed directly to surgery.
 Further testing IS recommended for this patient. The following test(s) are to be obtained prior to the planned surgical procedure: _____

MD/PA/NP Name (PRINT): _____ Date: _____

Provider Signature: _____ Phone Number: (____) _____

FAX COMPLETED FORMS ASAP: **Patients of Dr. Herzenberg: 410-630-3739**
Patients of Dr. Standard: 410-630-3738
Patients of Drs. Conway and Assayag: 410-844-0088
Patients of Drs. Bibbo and Siddiqui: 410-558-6489