



# HOSPITAL FOR SPECIAL SURGERY

TO BE COMPLETED BY HSS SURGEON OFFICE:

Date of Planned Surgery: \_\_\_\_\_

Name: \_\_\_\_\_

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

## History & Physical

Chief Complaint: \_\_\_\_\_

HPI: \_\_\_\_\_

### Past Medical History:

Blank area for Past Medical History

### Past Surgical History:

Blank area for Past Surgical History

### Medications:

Blank area for Medications

### Allergies:

Blank area for Allergies

### Social History

•Tobacco  Yes  No If yes, how much? \_\_\_\_\_ •Alcohol  Yes  No If yes \_\_\_\_\_ drinks/week  
•Other Drugs  Yes  No If yes, please specify: \_\_\_\_\_

Blank area for Social History

**Family History:**

- Bleeding History  Yes  No      • Anesthesia problems  Yes  No

**Review of Systems:**

**Obstructive Sleep Apnea**

- STOP-Bang Score: \_\_\_\_\_ (see STOP-Bang Sleep Apnea Questionnaire)  
• Diagnosed Sleep Apnea?  Yes  No    If yes, uses CPAP?  Yes  No

**Physical Exam:**

- Vital Signs: P \_\_\_\_\_ BP \_\_\_\_\_ R \_\_\_\_\_ Wt \_\_\_\_\_ HT \_\_\_\_\_ Pulse Ox \_\_\_\_\_  
• Skin: \_\_\_\_\_ • Lungs: \_\_\_\_\_ • Ext: \_\_\_\_\_  
• HEENT: \_\_\_\_\_ • Abd: \_\_\_\_\_ • Neuro: \_\_\_\_\_  
• Lungs: Normal Breath?  Yes  No If no, explain \_\_\_\_\_  
• Cardiovascular: Normal Rhythm?  Yes  No If no, explain \_\_\_\_\_  
Murmur  Yes  No If yes, explain \_\_\_\_\_

**Results:**

**Impression:**

**Medically Optimized for Surgery?**  Yes  No

**Plan:**

1. Medications to take the morning of surgery: \_\_\_\_\_
2. Medications to stop before surgery: \_\_\_\_\_
3. Recommendations: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_  
**Date:** \_\_\_\_\_