



**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	1	Name	Reaction
			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

General Appearance _____

Cardiovascular _____

Lungs and Thorax _____

HEENT _____

Neck _____

Abdomen _____

Genitourinary _____

Extremities _____

Mental Status _____

Neurological _____

VITAL SIGNS

Ht _____

Wt _____

BMI _____

BP – R _____

BP – L _____

Pulse _____

RR _____

Rest Sa O₂ _____

Exer Sa O₂ _____

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

1. Surgery specific risk Low Intermediate High Revised Cardiac Risk Index Score _____

2. Beta blockers to be started now with _____ contraindicated
 to be continued as _____ not indicated

3. 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

4. Antibiotic Prophylaxis _____

5. _____

6. _____

7. _____

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