

Chart # _____

Pre-op Assessment and History/Physical

Alaska Orthopaedic Specialists, Inc
David A. McGuire, MD

Pt. Name: _____

Weight: _____ Height: _____ BP _____ Pulse _____ Pulse Ox _____ Temp _____

Allergies: _____

Medications: _____

Eyes

Wear corrective lenses yes no
Glaucoma yes no

Ears

Hearing loss yes no
Hearing devices yes no
Ear disease or problems yes no

Nose

Sinus problems yes no

Cardiovascular

Chest pain yes no
Irregular or fast heartbeat yes no
Low blood pressure yes no
High blood pressure yes no
Heart disease or murmur yes no

Respiratory

Chronic or cough yes no
Shortness of breath yes no
Asthma or wheezing yes no
Emphysema yes no

Endocrine

Thyroid disease yes no
Bloody urine yes no
Diabetes yes no
Excessive thirst yes no

Hematological/Lymphatic

Bleeding / bruising yes no
Blood clotting yes no
Anemia yes no
Phlebitis yes no
Hepatitis: Type _____ yes no
HIV/AIDS yes no

Neurological

Fainting yes no
Seizures-epilepsy yes no
Stroke yes no
Paralysis of limbs yes no

Skin

Infections / Lesions yes no
Recent Tattoos yes no

Gastrointestinal

Nausea or vomiting yes no
Abdominal pain yes no
Heartburn yes no

Urinary

Excessive urination yes no
Kidney problems yes no
Infections yes no

Orthopaedic

Rheumatism yes no
Arthritis yes no
Gout yes no
Bone/joint infection yes no
Bone tumor/cyst yes no
Artificial joint yes no

Other Problems

Recent weight change yes no
Migraines yes no
Mental Health history yes no
Sleeping disorder / apnea yes no

Past surgical history: Please list all operations that you have had.

1. _____ Date: _____ 2. _____ Date: _____
3. _____ Date: _____ 4. _____ Date: _____

Family History: Please indicate who in your family has had any history as listed below.

Cancer: _____ Heart disease: _____ Lung problems: _____ Diabetes: _____
Gout: _____ Kidney problems: _____ High Blood Pressure _____

Patient's Social history Circle which one applies.

Do you drink alcohol? Do not drink Light/Social Occasional Moderate Heavy
Do you use any form of tobacco? Yes No What type: _____ How much: _____ How often: _____ How long: _____
If you quit smoking, how long since you quite? _____ What is your occupation: _____
Do you live alone? _____ What are your living arrangements: _____

Current medical history:

If yes please explain

Females: Pregnant at this time? Yes No

Do you have a cold at this time yes no _____
Do you have a fever: now or recently yes no _____
Do you have a severe sprain or broke bone yes no _____
Have you had recent dental work yes no _____
Do you have false teeth, loose caps yes no _____
Do you have any open sores yes no _____
Do you have a current infection yes no _____
Do you stomach ulcers/ stomach problems yes no _____
Have you had recent chest pain yes no _____
Have you had an EKG in the last 6mo yes no if so where? _____

Patient / Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____