ST. CLAIR MEMORIAL HOSPITAL
Pittsburgh, Pennsylvania 15243

N-5083

OUTPATIENT / SHORT STAY/ PRE-OP HISTORY AND PHYSICAL FORM

NAME _____ DATE OF SURGERY _____ DATE OF BIRTH _____

History of Present Illness (Describe Injury)_____

CONDITIONS Check (√) those conditions which the patient has or has had in the past which are deemed relevant to the procedure and/or anesthesia proposed.

CARDIOVASCULAR SYSTEM
- ☐ **Angina, (Severe Or Unstable)**
- ☐ **Cardiac Arrhythmia**
- ☐ **Coronary Artery Disease**
- ☐ **Heart Disease**
- ☐ **Heart Failure, (Decompensated Or Compensated Or History Of)**
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ **MI (History Of)**
- ☐ Pacemaker
- ☐ Phlebitis Or DVT
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Cancer Of
- ☐ **Valvular Disease**

EENT SYSTEM
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Migraine Headaches
- ☐ Seizure Disorder
- ☐ Cancer Of

CHILDHOOD DISEASE
- ☐ Polio
- ☐ Measles

GI SYSTEM
- ☐ Anorexia
- ☐ Bulimia
- ☐ **Diabetes (Type I Or II)**
- ☐ Diverticulosis
- ☐ GERD
- ☐ GI Disease
- ☐ Goiter
- ☐ Hepatitis
- ☐ Hernia
- ☐ Inflammatory Bowel Disease (IBD)
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Cancer Of

HEMATOLOGIC SYSTEM
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Cancer Of

RESPIRATORY SYSTEM
- ☐ Bronchitis
- ☐ COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Cancer Of

GU SYSTEM
- ☐ Pregnant
- ☐ Prostate Problem
- ☐ Abnormal
- ☐ AIDS
- ☐ Breast Lump
- ☐ Endometriosis
- ☐ Herpes
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Renal Insufficiency
- ☐ Vaginal Disease Severe
- ☐ Venereal Disease
- ☐ Cancer Of

MENTAL DISORDER
- ☐ Chemical/Drug Dependence
- ☐ Psychiatric Care
- ☐ Alcoholism
- ☐ Depression
- ☐ Suicide Attempt

MUSCULOSKELETAL SYSTEM
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Gout
- ☐ Cancer Of

Other Pertinent Information including family history:_____

Previous Surgery: YES ☐ NO ☐

1._____
2._____
3._____
4._____
5._____
6._____
7._____

Medications: YES ☐ NO ☐

1._____
2._____
3._____
4._____
5._____
6._____
7._____

Allergies: YES ☐ NO ☐ (list, if any)_____

Smoking: YES ☐ NO ☐ (packs/day)_____

Alcohol: YES ☐ NO ☐ (drinks/day)_____

Physical Examination: St. Clair Memorial Hospital

Name_____ **MR#**_____

Height:_____ **Weight:**_____ **B.P.**_____ **Pulse:**_____

YES	NO	Is Physical Examination of the Following Organs or Systems Normal?
☐	☐	Head, Eyes, Ears, Nose and Throat_____
☐	☐	Neck & Carotid Arteries_____
☐	☐	Lungs_____
☐	☐	Heart_____
☐	☐	Breasts_____
☐	☐	Axillae_____
☐	☐	Abdomen_____
☐	☐	Genitalia_____
☐	☐	Rectal_____
☐	☐	Extremities_____
☐	☐	Peripheral Pulses_____ (Carotid, radial, femoral, doralis pedis, posterior tibial)
☐	☐	Neurologic_____

PRINCIPAL DIAGNOSIS:_____

SECONDARY DIAGNOSES:_____

_____

_____

_____

_____

_____

_____ _____ _____
Physician's Signature Date Time

_____
Printed Name

Form #N-5083 (9/97; 2/99, 1/07; 10/08, 05/12, 05/14)
PRE OP

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OUTPATIENT SHORT STAY
HISTORY AND PHYSICAL FORM