PRE-OP FORM

Pt Name:____________________________ Exam Date:____________ Procedure Date:___________
Pt Age:___________ Temp:_____ BP:_____ HR:______ RR:______

Planned Procedure:
____
____
____

PMH:____
____
____
____

ROS:	Negative	Positive	If positive, please specify:
• Cardiovascular	☐	☐	______________________________
• Respiratory	☐	☐	______________________________
• CNS	☐	☐	______________________________
• GU	☐	☐	______________________________
PE:			
• HEENT	☐	☐	______________________________
• Breast	☐	☐	______________________________
• Pulmonary	☐	☐	______________________________
• Cardiovascular	☐	☐	______________________________
• Abdominal	☐	☐	______________________________
• Musculoskeletal	☐	☐	______________________________
• Neurologic	☐	☐	______________________________
• Genitourinary	☐	☐	______________________________

Assessment & Plan:
____
____
____

Recommendations prior to surgery:
____
____
____

Physician signature: _______________________ Date: ________________