Job I.D.# ____________
or
Dictated to ____________

PA/NP ____________

New Patient/Consult Pre-Op Evaluation

PHYSICIAN ____________ DATE ____________ REF. MD ____________ CLINIC SITE ____________

PLEASE COMPLETE BLACK PRINTED AREAS

REASON FOR YOUR VISIT ____________

____

____

CARDIAC HISTORY *(Circle appropriate response)*

1.	Heart attack If yes, when? ____________	YES	NO
2.	Coronary artery dye test If yes, when? ____________	YES	NO
3.	Heart surgery or balloon/stent procedure Date ____________ Type ____________	YES	NO
4.	Echocardiogram *(ultrasound of heart)*	YES	NO
5.	Chest pain, tightness, heaviness	YES	NO
6.	Are you short of breath with activity?	YES	NO
7.	Do you wake up gasping for air?	YES	NO
8.	Do you require more than one pillow to sleep on?	YES	NO
9.	Legs and ankles swell?	YES	NO
10.	Heart skips beats or pounds/beats too fast?	YES	NO
11.	Fainting?	YES	NO
12.	Dizziness/Lightheadedness?	YES	NO
13.	Pericarditis?	YES	NO
14.	Rheumatic fever?	YES	NO
15.	Heart murmur?	YES	NO

VASCULAR HISTORY

1.	Pain in calves/thighs/buttocks when walking? How far do you walk prior to pain? ____________	YES	NO
2.	Any sores on legs/feet?	YES	NO
3.	Previous surgery on arteries *(legs, abdomen, neck)*	YES	NO
4.	Aneurysm *(ballooning of artery)*	YES	NO
5.	Previous carotid doppler *(ultrasound of arteries of neck)*	YES	NO
6.	Previous arterial doppler *(leg circulation test)*	YES	NO
7.	Blood clots in legs/lungs	YES	NO
8.	Varicose veins	YES	NO

CARDIOVASCULAR RISK FACTOR SURVEY

1.	Do you smoke/chew tobacco or have you in the past? a. Packs/day ____ b. Years smoked ____ c. Year quit ____	YES	NO
2.	Do you have a history of high blood pressure? How long? ____________	YES	NO
3.	Do you have a history of high blood cholesterol?	YES	NO
4.	Are you diabetic? If yes, how long? ____________	YES	NO

5. Is there a family history of . . .

			Please list relationship
a. Heart Disease	YES	NO	____________
b. Diabetes	YES	NO	____________
c. Cancer	YES	NO	____________
d. Stroke	YES	NO	____________

OVER

PATIENT NAME ____________ Age ____________

QSI # ____________ Gender Male Female

For Office Use Only

VITALS: HT. ______ WT. ______ WAIST ______

B.P. RT. ______/______ LT. ______/______

PULSE ______ R. ______ T. ______

ABI's: R)______ L)______ by ______

MEDICATION ALLERGIES: ☐ See Medication Coordination Form

____

MEDICATIONS/02/CPAP

☐ See Medication Coordination Form

____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________

NURSE/ASSISTANT ____________
Signature

Physician: ____________ Room # ______

FILE IN PERMANENT RECORD

PAST MEDICAL HISTORY:
Previous Surgeries & Chronic Conditions

Type	*Date*

HABITS/SOCIAL HISTORY: Please Circle

1. Do you follow a special diet?	YES	NO
2. Do you use caffeine?	YES	NO
a. Amount/day? ____________		
3. Do you use alcohol?	YES	NO
a. Amount/day? ____________		
4. Do you have a history of drug use/abuse?	YES	NO

5. Occupation____________ Marital Status ____________

REVIEW OF SYSTEMS: Please Circle

A. GENERAL

a. Do you tire easily?	YES	NO
When did you first notice? ____________		
b. Have you had a recent fever, chills or sweats?	YES	NO
c. Have you had a recent weight loss/gain?	YES	NO
Amount __________		

B. EYES

Have you ever had

a. Blurry vision	YES	NO
b. Glaucoma	YES	NO
c. Partial or total loss of vision/lenses	YES	NO
d. Cataracts	YES	NO

C. THROAT, MOUTH, AND EARS

Do you have any problems with

a. nose	YES	NO
b. sinus	YES	NO
c. throat	YES	NO
d. hearing/ears	YES	NO

Comment: ______________________________

D. RESPIRATORY

Have you had

a. Asthma or wheezing?	YES	NO
b. Emphysema or bronchitis?	YES	NO
c. Chronic cough?	YES	NO
d. Bloody sputum?	YES	NO
e. Do you snore loudly?	YES	NO
f. Do you wake up more than once a night?	YES	NO
g. Are you tired first thing in the AM?	YES	NO

E. GASTROINTESTINAL

Do you have

a. Heartburn	YES	NO
b. Sour regurgitation/acid reflux	YES	NO
c. Difficulty swallowing	YES	NO
d. Hiatal hernia	YES	NO
e. Stomach ulcer	YES	NO
f. Rectal bleeding/black or bloody stools	YES	NO
g. Gall bladder problems	YES	NO
h. Liver disease/Hepatitis	YES	NO

F. GENITO-URINARY TRACT

Do you have

a. Blood in urine	YES	NO
b. Problems with urination	YES	NO
c. Urinary Infections	YES	NO
d. Kidney/Bladder Stones	YES	NO
e. Kidney failure/Dialysis	YES	NO

G. MUSCULOSKELETAL

Have you had

a. Arthritis	YES	NO
b. Gout	YES	NO
c. Muscle or Joint Pains	YES	NO

H. ENDOCRINE

a. Have you had thyroid problems?	YES	NO

I. HEMATOLOGY/LYMPHATIC

Have you had

a. Anemia	YES	NO
b. Bleeding problems	YES	NO
c. Cancer	YES	NO
Where?______________		

J. NEUROLOGIC

Have you had

a. Chronic Headaches	YES	NO
b. Stroke	YES	NO
c. Seizure disorder	YES	NO
d. Numbness/tingling	YES	NO

K. PSYCHIATRIC

a. Do you have a history of mental illness?	YES	NO
b. Have you been diagnosed with depression?	YES	NO
c. Do you have an anxiety problem?	YES	NO

Completed by______________________________
Signature

Reviewed by______________________________
Signature

PHYSICAL EXAM TEMPLATE:

VITAL SIGNS:	**3 Vital Signs**
SKIN:	pink warm dry
HEENT:	sclerae xanthelasmas oral mucosa JVD carotids
CHEST:	**respirations lungs**
HEART:	**rhythm S1 and S2 murmurs rubs gallops**
ABDOMEN:	soft nontender organomegaly abdominal bruits
EXTREMITIES:	**peripheral pulses edema**
PSYCH:	alert and oriented mood affect

BOLD = Limited [illegible]ical Exam