

PRE-OP ANESTHESIA GUIDELINES FOR HCGH

NOTE - FOR ALL PROCEDURES (NO EXCEPTIONS) REQUIRED:

- ALL PATIENTS REQUIRE Pre- Op History & Physical WITHIN 30 DAYS (preferably within 14 days)
- D/C PHENTERAMINE AND ALL HERBAL MEDICATIONS AND TEAS 2 WEEKS PRIOR TO PROCEDURE
- ALL FEMALES OF CHILDBEARING AGE REQUIRE PREGNANCY TEST AT HCGH PRIOR TO PROCEDURE

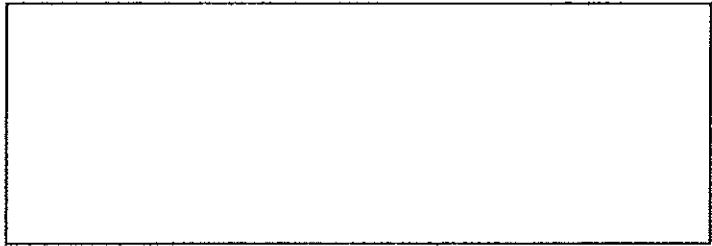
NOTE - SPECIFIED PROCEDURES REQUIRE (SEE SURGEONS PRE- OP ORDERS):

- Pre- Op H&P WITHIN 30 DAYS (preferably within 14 days)
- Labs: CBC, CMP (Preferably within 14 days, but NO LONGER than 30 days prior to procedure)
- EKG (within 90 days of procedure)

NOTE:

- SLEEP APNEA - Instruct Patient to Bring C-PAP machine to surgery
- PATIENTS ON LITHIUM - Lithium level
- PATIENTS ON COUMADIN - INR/Coags
- PATIENTS ON ADRIAMYCIN - Echocardiogram
- PATIENTS ON DIGOXIN - Digoxin level

NOTE: AVOID COSTLY CANCELLATIONS AND DELAYS- HCGH MUST RECEIVE ALL SURGEON APPROVED PAPERWORK NO LATER THAN 5 BUSINESS DAYS PRIOR TO THE CASE.



HISTORY AND PHYSICAL
Page 1 of 2

PATIENT NAME: _____ DOB: _____ DATE OF VISIT: _____
 PLANNED SURGERY / HISTORY AND PRESENT ILLNESS: _____

Food & Drug Allergies/Reactions <input type="checkbox"/> None _____ _____ <input type="checkbox"/> Latex Allergy <input type="checkbox"/> None	Medications (prescribed medication, over the counter medications) - Listed or Attached <input type="checkbox"/> None _____ _____ _____ _____
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Family History: <input type="checkbox"/> None Contributing _____ _____	Surgical History: <input type="checkbox"/> None Contributing _____ _____
Social History: <input type="checkbox"/> None Contributing _____ _____	

*Note: Check Box if past/present history of the following. If none, please check the appropriate box.

Cardiovascular Disease <input type="checkbox"/> Chest Pain/Tightness/Pressure/Heart Attack <input type="checkbox"/> None <input type="checkbox"/> Irregular Heart Beat/Palpitations/A-Fib <input type="checkbox"/> Pacemaker/Defibrillator Brand _____ <input type="checkbox"/> Problem with circulation <input type="checkbox"/> Blood Clot in legs or lungs <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> History of Rheumatic Fever/Heart Valve Disorder <input type="checkbox"/> Echo/Stress Test Date _____ <input type="checkbox"/> Leg cramps when walking short distance <input type="checkbox"/> Shortness of breath at night <input type="checkbox"/> Sleep with 2 or more pillows <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Other <input type="checkbox"/> Cardiologist: _____ # _____	Respiratory Disease <input type="checkbox"/> Smoking _____ packs per day; <input type="checkbox"/> None <input type="checkbox"/> Quit _____ <input type="checkbox"/> Asthma <input type="checkbox"/> Treated for TB <input type="checkbox"/> Emphysema/bronchitis/productive cough <input type="checkbox"/> Home Oxygen Therapy <input type="checkbox"/> Shortness of breath at rest <input type="checkbox"/> Upper respiratory infection (cold) within two weeks <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Use CPAP <input type="checkbox"/> Had or told you need a Sleep Study <input type="checkbox"/> Pulmonologist: _____ # _____
Neurological Disorder <input type="checkbox"/> Stroke or mini-stroke (T.I.A.) <input type="checkbox"/> None <input type="checkbox"/> Carotid Blockage <input type="checkbox"/> Seizures <input type="checkbox"/> Back or Neck Problems <input type="checkbox"/> Physical restrictions/limitations <input type="checkbox"/> Forgetfulness/memory loss/ confusion <input type="checkbox"/> Multiple Sclerosis/muscular dystrophy <input type="checkbox"/> Nerve/Spinal cord injury <input type="checkbox"/> Neuropathy/Myopathy <input type="checkbox"/> Neurologist: _____ # _____	Skin <input type="checkbox"/> Ulcers/open wound/rashes <input type="checkbox"/> None
<input type="checkbox"/> Eye Disorder/Glaucoma/Retinal Detachment <input type="checkbox"/> None	Blood Disorder <input type="checkbox"/> Abnormal Bleeding tendency <input type="checkbox"/> None <input type="checkbox"/> Taking Blood thinners (such as aspirin, Coumadin, or Plavix) <input type="checkbox"/> Sickle cell disease or trait <input type="checkbox"/> Chronic anemia <input type="checkbox"/> History of Blood Transfusion <input type="checkbox"/> Religious or other objections to blood transfusion <input type="checkbox"/> HIV positive/AIDS <input type="checkbox"/> Hematologist: _____ # _____
	<input type="checkbox"/> Ear Disorder/"Ringing" in ears <input type="checkbox"/> None <input type="checkbox"/> Hearing loss

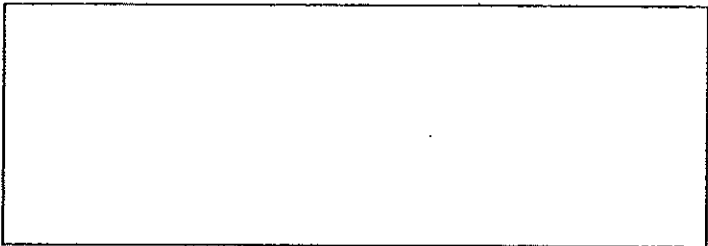


**HOWARD COUNTY
GENERAL HOSPITAL**

JOHNS HOPKINS MEDICINE



HC17054-1



HISTORY AND PHYSICAL
Page 2 of 2

PATIENT NAME: _____		DOB: _____	
<input type="checkbox"/> Thyroid Problem <input type="checkbox"/> If yes, specify _____		<input type="checkbox"/> None <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> If yes, specify _____	
Anesthesia Related Information <input type="checkbox"/> Anesthesia within one year <input type="checkbox"/> History of difficult intubation <input type="checkbox"/> Any objection to spinal/epidural anesthesia <input type="checkbox"/> Arthritis in jaw/neck/back <input type="checkbox"/> Difficulty opening mouth/TMJ <input type="checkbox"/> Adverse reaction to anesthesia <input type="checkbox"/> Relative with Malignant Hyperthermia <input type="checkbox"/> Nausea or vomiting after anesthesia		<input type="checkbox"/> None Other illness or disease <input type="checkbox"/> If yes, specify _____ For women ONLY <input type="checkbox"/> First day of last menses: _____ <input type="checkbox"/> Post menopause/hysterectomy	
Because drugs may interact adversely with anesthesia, please indicate the following: <input type="checkbox"/> History of regular alcohol use or within 24 hours <input type="checkbox"/> Use of steroids/cortisone in the past year <input type="checkbox"/> History of "street drug" use or within 30 days <input type="checkbox"/> Use of diet pills in 3 months		<input type="checkbox"/> Infectious Diseases <input type="checkbox"/> None <input type="checkbox"/> Kidney/Bladder/Prostate Disorder <input type="checkbox"/> None <input type="checkbox"/> If yes, specify _____ <input type="checkbox"/> Stones/Infections/frequent UTI <input type="checkbox"/> Inability to urinate after anesthesia <input type="checkbox"/> Dialysis: Schedule _____	
Recent HX of: <input type="checkbox"/> Coumadin <input type="checkbox"/> Steroids <input type="checkbox"/> Contagious Disease		<input type="checkbox"/> Aspirin <input type="checkbox"/> Herbal Supplements/Diet Pills <input type="checkbox"/> CPAP <input type="checkbox"/> None	
PHYSICAL EXAM: Temp: _____ P: _____ R: _____ BP: _____ Ht: _____ Wt: _____			
General/Reliability _____			
Head/Neck _____			
Lungs/Thorax _____			
Heart/Pulse/Veins _____			
Breasts _____			
Abdomen _____			
Genito/Rectal _____			
Musculoskeletal _____			
Skin _____			
Neuro/Psych _____			
LABS: <input type="checkbox"/> CBC <input type="checkbox"/> CHEMISTRY <input type="checkbox"/> PT/PTT <input type="checkbox"/> EKG <input type="checkbox"/> CHEST X-Ray			
OTHER: _____			
<input type="checkbox"/> Cleared for Surgery <input type="checkbox"/> Not Cleared for Surgery <input type="checkbox"/> Cleared for Surgery Pending: _____			
Date: _____		Time: _____	
Phone Number: _____		Physician's Signature: _____	
		Physician's Printed Name: _____	