

Pike Medical Consultants Preoperative Evaluation

Patient Name _____

Date of Birth _____

*****PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT*****

Issues that Prompted Surgery _____

Upcoming Surgery _____

Surgeon _____ Proposed Date _____

Have You Ever Had a Cardiac Evaluation (EKG, Echocardiogram, Stress Test, Catheterization)?

Where/When _____

Results _____

Cardiologist _____

Past Medical History

<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blood Clot <input type="checkbox"/> Bowel Obstruction <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Chronic Pain <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Colitis/Crohn's <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Constipation <input type="checkbox"/> Dementia <input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes <input type="checkbox"/> Diarrhea <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Emphysema <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Headache <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> HIV <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Insomnia <input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lupus <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Recurrent Infections <input type="checkbox"/> Skin Problems <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Staph infections/MRSA <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Vascular Disease Additional History _____ _____ _____
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Reviewed _____ Date _____

Patient Name _____

Past Surgical History

Surgery	Approx. Date	Surgeon	Hospital	Outcome	Complications?

Family History

	Age	Heart Disease	Stroke	Cancer	Blood Clot	Diabetes	Other Inherited Illness
Mother							
Father							
Siblings							
Children							

Social History

Single Married Divorced Widowed

	Type	Quantity Daily	Years of Use	Methods Used	Ever Tried to Quit?	Ever Had Withdrawal?
Tobacco						
Alcohol						
Drugs						

Occupation _____ Exercise _____

Current Medications

Name	Dose	Frequency

Reviewed ____ Date _____

Herbs, Supplements and Vitamins

Allergies

Medication Allergy	Reaction

Within the Past 12 Months, Have You Had:

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Feeling Poorly	<input type="checkbox"/> Feeling Tired	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Eye Redness	<input type="checkbox"/> Vision Change	<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Itchy Eyes
<input type="checkbox"/> Earache	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Slow Heart Rate	<input type="checkbox"/> Fast Heart Rate	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Leg Swelling	
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Snoring	<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/> Shortness of Breath on Exertion
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Tarry Stool				
<input type="checkbox"/> Urinary Burning	<input type="checkbox"/> Urinary Incontinency		<input type="checkbox"/> Recurrent Urinary Infection		<input type="checkbox"/> Pelvic Pain
<input type="checkbox"/> Urinary Frequency		<input type="checkbox"/> Urinary Retention			
<input type="checkbox"/> Skin Lesions	<input type="checkbox"/> Skin Wounds	<input type="checkbox"/> Skin Infections	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Itching	<input type="checkbox"/> Change in a Mole
<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Breast Lump				
<input type="checkbox"/> Confusion	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Weakness	
<input type="checkbox"/> Suicidal Thoughts/Attempts	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression		
<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Swollen Glands		

Please Provide Details

Reviewed _____ Date _____

Patient Name _____

Additional Information Not Listed Above

To the best of my knowledge, all of the above statements are true and accurate.

Patient Signature _____

Date _____

Records Requested

Records Reviewed

Reviewed By _____