Mount Sinai

060

PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

Planned Surgical Procedure: _____

Date Planned Surgery: _____ **Hospital/Location of Surgery:** _____

Attending Surgeon: _____

History of Present Illness:

☐ **All relevant preoperative PMH listed below was reviewed and found to be negative unless specified below.**

Past Medical History	Yes	Date
CKD Stage _____ /Dialysis		
TIA/CVA/hemiplegia/hemparesis/residual deficit _____		
DVT/PE		
Anemia		
Active infection/sepsis		
Asthma/COPD		
Chronic Resp Failure on Home O2		
Cancer		
Chronic Steroids		
Cirrhosis		
Coagulopathy/on anticoagulation		
Diabetes (Insulin Yes / No)		
HIV/AIDS		
Chronic Hepatitis B/C /treated		
Obesity w/hypoventilation syndrome		
OSA (if yes, is the patient adherent to CPAP?)		
STOPBANG		
Other:		

Cardiac History	Yes	Date
Pulmonary Hypertension (latest PAP ___)		
Congenital heart disease		
MI (yes, no, <30d)		
PCI Stent (bare / drug)		
Angina (unstable / stable / severe)		
HTN (yes, no, controlled)		
CAD (History of abnormal stress test or Q waves on EKG)		
Chronic systolic/diastolic CHF (compensated / not)		
Cardiomyopathy		
Valve disease (symptomatic / severe AS, MS, MR)		
Arrythmia		
PM/ICD (manufacturer, indication, device settings, when last interrogated)		

Allergies/Reaction ☐ **NKDA**

Past Surgical History

Social History

☐ **ETOH/Drinks per week:**

☐ **Smoking status, # pack years:**

☐ **Counseling provided?**

☐ Other substance abuse:

_____

_____

_____

_____

☐ Jehovah's Witness

Prior anesthesia complication?

History of difficult intubation

☐ Yes ☐ No

If yes, describe:

_____

_____

_____

_____

Other Relevant History

Pregnant: ☐ Yes ☐ No

Birth Control: ☐ Yes ☐ No

Family Hx:

Other:

Medications	Dose	Continue? Yes	No

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Review of Systems: All systems were reviewed and found to be negative except as per HPI or specified below:
(circle all that apply)

System	Symptoms	Negative
Gen	weight loss or gain, fatigue, fever or chills, weakness, trouble sleeping	☐
CVS	chest pain, irregular heartbeat, SOB, difficulty breathing at night, swollen legs or feet	☐
Resp	chronic dry cough, coughing up blood, wheezing or night sweats	☐
HEENT	double or blurred vision, loss of hearing, nosebleeds, dentures	☐
Heme	bleeding tendency or clotting tendency	☐
GI	nausea, vomiting, diarrhea, black stools, abdominal pain	☐
GU	difficult urination, burning with urination, blood in the urine	☐
Vascular	calf pain with walking, leg cramping	☐
Musculoskeletal	muscle or joint pain, stiffness, back pain, redness of joints, swelling of joints, trauma	☐
Neuro	headache, dizziness, fainting, LOC, memory loss	☐
Psych	nervousness, stress, depression, memory loss	☐
Other		☐

Physical Exam

BP _____ HR _____ T _____ RR _____ HT _____ WT _____ BMI _____ SaO_2 _____

Check for normal exam, indicate abnormal findings and describe

General	☐ A&O x 3 ☐ NAD
ENT	☐ throat clear
Neck	☐ no bruits ☐ no JVD
CV	☐ RRR ☐ no murmurs, rubs, gallops
Lungs	☐ CTA bilat. ☐ no wheezes or rhonchi ☐ nl resp. effort
Abd	☐ soft ☐ ND/NT
Ext	☐ no clubbing, cyanosis, or edema ☐ nl pulses
Neuro	☐ nl and equal strength
Other	

Test	Date	Results
CXR		
EKG		
Echo		
Stress Test		
Cardiac Cath		
Other Studies		

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Surgical Risk For Planned Procedure:

Risk of Planned Surgical Procedure (low, intermediate, high)

High risk cardiac conditions (Unstable angina, decompensated CHF, significant arrhythmia or significant valvular disease)

Cardiac Risk Assessment:

Determination of risk - Please use whichever risk stratification tool (e.g. RCRI, Gupta, NSQIP) that is most appropriate to this patient and this procedure.

RCRI Risk Score: _____ (High-risk surgical procedure, ischemic heart disease, heart failure, CVA/TIA, DM on Insulin, chronic renal insufficiency)

☐ The patient has a (low / elevated) risk of a major cardio vascular event.

If elevated, please specify patient's Metabolic Equivalents (METs): ☐ >4 ☐ <4 ☐ Unable to assess.

Non-Cardiac Risk Assessment:_____

Further testing indicated: ☐ Yes ☐ No

Further consults indicated: ☐ Yes ☐ No

Recommendations: _____

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PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

PGY/NP/PA Name (printed) _____ Date _____ Time _____

PGY/NP/PA Signature _____ Contact #_____

☐ *I have interviewed and examined the patient. I have confirmed the plan of care with the Resident/NP/PA.*

Attending Signature _____ Date _____ Time _____

Print Name _____

☐ **I have reviewed the Pre-Operative Medical Assessment and acknowledge its findings.**
I have discussed the alternative treatment options and the potential risks and anticipated benefits of the planned procedure with the patient and/ or his/her family in light of the POMA findings.
All questions have been answered.

Reviewed by: Attending Surgeon's Signature _____ Date _____ Time _____

Print Name _____