JOHNS HOPKINS
MEDICINE

THE JOHNS HOPKINS HOSPITAL
PRE–OPERATIVE EVALUATION

PATIENT NAME: _____ HISTORY #: _____

Date:_____Age:_____ ☐ Male ☐ Female

Diagnosis: _____

Surgery Planned and Date: _____

Surgeon: _____

Chief Complaint: _____

_____

Past Medical History: _____

Family Medical History: _____

_____

Social History: _____

_____

Past Surgical History: _____

_____

Allergies: _____

_____

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

HISTORY OF PRESENT ILLNESS:_____

REVIEW OF SYSTEMS

Yes	No	**Cardiovascular**
☐	☐	MI
☐	☐	Hypertension
☐	☐	Arrhythmia
☐	☐	Angina
☐	☐	CHF
☐	☐	Valvular Disease
☐	☐	Peripheral Vasular Disease
☐	☐	Past Cardiac Disease
☐	☐	Other: _____

Yes	No	**Pulmonary**
☐	☐	Smoking HX
☐	☐	Asthma
☐	☐	COPD/Emphysema/BPD
☐	☐	Other: _____

Yes	No	**Renal**
☐	☐	Renal Failure
☐	☐	Other: _____

Yes	No	**Hepatic**
☐	☐	Hepatitis
☐	☐	Other: _____

Yes	No	**Endocrine**
☐	☐	Diabetes
☐	☐	Other: _____

Yes	No	**Infections**
☐	☐	SBE Prophylaxis
☐	☐	Other: _____

Yes	No	**Neurologic**
☐	☐	Seizure
☐	☐	Elevated ICP
☐	☐	Cerebrovascular Disease
☐	☐	Neuromuscular Disease
☐	☐	Other: _____

Yes	No	**Gastrointestinal**
☐	☐	G.E. Reflux/Hiatal Hernia
☐	☐	Bowel Obstruction
☐	☐	Other:_____

Yes	No	**Hematologic**
☐	☐	Sickle Cell
☐	☐	Coagulopathy
☐	☐	Transfusion
☐	☐	Transfusion within last 3 months
☐	☐	Accept Transufion

Yes	No	**Pediatrics**
☐	☐	Prematurity
☐	☐	Congenital Anomaly
☐	☐	Apnea
☐	☐	Other: _____

Yes	No	**Obstetrics**
☐	☐	Pre-eclampsia/Eclampsia
☐	☐	Prematurity
☐	☐	Placenta/Previa Abruptio
☐	☐	LMP: _____
☐	☐	Other: _____

Yes	No	**Drug Use**
☐	☐	ETOH
☐	☐	Other: _____

Physical Examination: Ht: _____ Wt. _____ Temp. _____ Pulse _____ Resp. _____ BP _____

General Appearance: _____

HEENT: _____

Heart/Vessels: _____

Lungs: _____

Abdomen: _____

Neurological: _____

Musculoskeletal: _____

Genitalia/Rectum: _____

Assessment: _____

Signature (Licensed Practitioner): _____ **Date:** _____

Pre-operative history, physical examination and pertinent laboratory data reviewed by me with amendments as follows:
☐ **NONE** _____

_____

Pre-operative Diagnosis: _____

Planned Procedure: _____

_____

Surgeon Signature: _____ **ID Number:** _____ **Date:** --_____