Midwest Orthopaedics at Rush
Dr. Jorge Chahla, MD, PhD
1611 W Harrison Street, Suite 300
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P: 312.432.2531
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Pre-Operative Clearance

History and Physical Exam

PATIENT NAME _____

DATE OF BIRTH ___/___/_____ DATE COMPLETED ___/___/_____

PLEASE RETURN COMPLETED FORM TO DR. JORGE CHAHLA's OFFICE AS SOON AS POSSIBLE VIA EMAIL (chahlaadmin@rushortho.com) or FAX (708.409.5179)

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CHIEF COMPLAINT Informant: ☐ Patient ☐ Relative _____ ☐ Other _____

HISTORY OF PRESENT ILLNESS

CURRENT MEDICATIONS ☐ NONE (include OTC, supplements, drops, inhalants, patches, oxygen)

ALLERGIES/ADVERSE DRUG REACTIONS ☐ NKDA (specify reaction)

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PAST MEDICAL HISTORY

PAST SURGICAL HISTORY (include name of surgeon, hospital and date for each procedure)

SOCIAL HISTORY ☐ HAVE YOU SMOKED WITHIN THE LAST 12 MONTHS?

Tobacco ☐ NONE ☐ ACTIVE ☐ QUIT _____ PK/YRS: _____ ☐ SMOKELESS ☐ QUIT ATTEMPTS _____

Alcohol ☐ NONE FREQUENCY _____ LAST DRINK _____ HX DT/DETOX: _____

Caffeine _____ Illicit drugs ☐ NONE TYPE(S): _____

Occupation _____ Exposures _____

Living situation _____ Travel _____

Diet _____ Nutrition counseling _____ Exercise _____

Other _____

IMMUNIZATION STATUS N=never U=unknown or list year last given - include in plan if update needed

Tetanus _____ Pneumovax _____ Influenza _____ Hepatitus B _____ Varicella _____

PPD _____ Childhood _____

FAMILY MEDICAL HISTORY

Parents _____

Siblings _____

Other _____

REVIEW OF SYSTEMS ☐ Unable to obtain ROS due to

			Line through negatives; circle positives and describe
1. GENERAL		☐ **No abnormals**	
Fever	Chills	Adenopathy	
Anorexia	Diaphoresis	Lightheadedness	
Weight gain	Weight loss	Edema	
2. ENDOCRINE/METABOLIC		☐ **No abnormals**	
Throid disorder	Temp intolerance	Goiter	
Radiation exposure	Diabetes	Lipid disorder	
3. HEMATOLOGIC		☐ **No abnormals**	
Anemia	Sickle cell	Leukemia	
Transfusions	Bruising	Bleeding	

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4. SKIN ☐ **No abnormals**

Pruritus	Rash	Mole changes
Skin cancer	Tattoos	Hair or nail changes

5. EYES ☐ **No abnormals**

Corrective lenses	Cataracts	Glaucoma
Photophobia	Visual change	Laser surgery

6. ENT ☐ **No abnormals**

Infections	Hearing loss	Vertigo
Tinnitus	Epistaxis	Hoarseness

7. ORAL ☐ **No abnormals**

Condition of teeth	Dentures	Lesions
Pain	Infections	Dysgeusia

8. CARDIOVASCULAR ☐ **No abnormals**

Chest pain	Chest pressure	Palpitations
Syncope	Orthopnea	PND
MI	Hypertension	Cardiac cath
Murmur	Rheumatic fever	Dysrhythmia
Claudication	Aneurysm	Varicosities
DVT/PE	Thrombophlebitis	Raynaud's

9. PULMONARY ☐ **No abnormals**

Dyspnea	Cough	Hemoptysis
Asthma/COPD	Wheezing	Tuberculosis
Positive PPD	TB exposure	

10. BREASTS ☐ **No abnormals**

Mass	Tenderness	Discharge
Asymmetry	Gynecomastia	Implants

Mammograohy (include dates and provider

11. GASTROINTESTINAL ☐ **No abnormals**

Dysphagia	Odynophagia	Heartburn
Abdominal pain	Nausea/vomiting	Hematemesis
Hematochezia	Melena	Diarrhea
Constipation	Ulcers	Hepatitis
Pancreatitis	Gallstones	Colitis
Jaundice	Hemorrhoids	Hernia

Fecal occult blood/endoscopy (include dates and results)

12. MUSCULOSKELETAL ☐ **No abnormals**

Pain	Arthritis	Deformity
Stiffness	Swelling	Injury

13. NEUROLOGIC ☐ **No abnormals**

Paresthesia	Paralysis/paresis	Headache
Head trauma	Syncope	CVA/TIA
Seizures	Tremor	Weakness
Gait abnormality	Dysarthria	

14. PSYCHIATRIC ☐ **No abnormals**

Anxiety	Depression	Psychosis
Memory loss	Psych treatment	

15. GENITOURINARY ☐ **No abnormals**

Hematuria	Dysuria	Urgency
Frequency	Nocturia	Incontinence
Change in stream	Infection	Nephrolithiasis

16. GENITOREPRODUCTIVE ☐ **No abnormals**

ALL	**Multiple partners**	**STD's**	
MALE	Impotence	Pain	Mass
	Testicular self exam	Penile discharge	
FEMALE	Abnormal bleeding	Dyspareunia	PMS
	Hormone use	Contraception	Infertility

17. OB/GYN: complete below

G____P ___ ___ ___ ___ FDLMP

Menarche _____ Menopause _____

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PHYSICAL EXAMINATION

VITALS Temp _____ **HR** ____ /min **RR** ____ /min **BP** supine _____ BP seated/standing _____

Height _____ **Weight** _____ lb / kg (actual / est) **Pulse ox** _____ % on _____ **Pain** _____

1. GENERAL
Status — General appearance
Skin color — Acutely / chronically ill
Orientation — Level of consciousness

2. EYES ☐ **No abnormals** ☐ **Not done**
Pupils — Conjunctiva
Fundus — Extraocular motion

3. ENT ☐ **No abnormals** ☐ **Not done**
Head — Hearing
EAC — Tympanic membranes
Nasel Mucosa — Gums and teeth
Pharynx — Tongue

4. NECK ☐ **No abnormals** ☐ **Not done**
Mobility — Trachea
Thyroid — Masses

5. LUNGS ☐ **No abnormals** ☐ **Not done**
Wheeze — Rhonchi
Rales — Friction rub
Dullness — Abnormal breath sounds

6. HEART ☐ **No abnormals** ☐ **Not done**
Rate — Rhythum
Heart sounds — Murmur
Rub — PMI

7. VASCULAR ☐ **No abnormals** ☐ **Not done**
Pulses — Bruits
Stasis — Varicosities
Edema — Capillary refill

8. ABDOMEN ☐ **No abnormals** ☐ **Not done**
Bowel sounds — Tenderness
Distension — Abnormal percussion

9. RECTAL ☐ **No abnormals** ☐ **Not done**
Sphincter tone — Masses
Hemorrhoids — Gross/occult blood

10. NEURO ☐ **No abnormals** ☐ **Not done**
Cranial nerves — Cerebellar function
Meningismus — Deep tendon reflexes
Muscle strength — Pathologic reflexes
Sensation — Fine motor

11. LYMPH ☐ **No abnormals** ☐ **Not done**
Cervical — Occipital
Supraclavicular — Axillary
Inguinal — Epitrochlear

12. SKIN ☐ **No abnormals** ☐ **Not done**
Turgor — Lesions

13. BREASTS ☐ **No abnormals** ☐ **Not done**
Skin changes — Nipple inversion
Mass — Tenderness
Asymmetry — Discharge

14. GENITAL ☐ **No abnormals** ☐ **Not done**
Male: Penis Urethra Testicles Prostate
Female: External genitalia Urethra Vagina Cervix Adnexa Uterus

Circle abnormals and describe. If exam not done, document reason. If patient refuses exam, document that risks of not completing exam were discussed with patient.

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DIAGNOSTIC FINDINGS

Other _____

IMPRESSIONS

PLAN

Print name _____ **Signature** _____ **Date** _____

Reviewed by _____ (Int/Res) **Signature** _____

ATTENDING PHYSICIAN STATEMENT: I have personally interviewed and examined this patient and have reviewed this history and physical examination

☐ **I agree with H&P as stated** ☐ **I have made corrections as indicated above or in progress notes**

Signature of attending _____ **Date reviewed** _____

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Surgery may be canceled if not received within 7 days of the scheduled procedure.

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