MUNSON HEALTHCARE

0545

NAME	D.O.B.	DATE OF EXAM

HISTORY

CHIEF COMPLAINT / PRESENT ILLNESS

FAMILY/SOCIAL HISTORY

SMOKER: ☐ NO ☐ YES - AMOUNT_____

ALCOHOL INTAKE: ☐ NO ☐ YES - AMOUNT_____

OTHER:

PAST MEDICAL HISTORY

PROBLEMS
1
2.
3.

OPERATIONS

ALLEGIES (IF YES, PLEASE SPECIFY)	TRANSFUSION REACTIONS (IF YES, PLEASE SPECIFY)	SPECIAL DIET (IF YES, PLEASE SPECIFY)
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

CURRENT MEDICATIONS (IF YES, PLEASE LIST)
☐ YES ☐ NO

REVIEW OF SYSTEMS

PHYSICAL EXAM	B/P	PULSE	RESP.	TEMP.	HEIGHT	WEIGHT

CHECK BOX IF NORMAL

Notes:

HEENT & NECK	☐
HEART	☐
LUNGS	☐
BREASTS	☐
ABDOMEN	☐
GENITAL (pelvic & rectal)	☐

ADMITTING & OTHER DIAGNOSES

1
2.
3.
4.
5.
6.

COURSE OF ACTION PLANNED

IS MUNSON SURGICAL RISK INDEX GREATER THAN OR EQUAL TO 3?	IF MSRI ≥ 3 PRE-OP EVALUATION BY:	INPATIENT MEDICAL MANAGEMENT BY:
☐ YES ☐ NO		☐ N/A

PATIENT ID LABEL HERE

PROCEDURES

SIGNATURE	DATE	TIME

48 HOUR OR LESS STAY HISTORY AND PHYSICAL