



Hudson Yards Surgery Center Pre-Operative Medical Evaluation

450 West 31<sup>st</sup> Street 2S New York, NY 10001

Phone: (646)930-2700 Fax: (646)609-1350

Patient's Name:	DOB:
Surgeon:	Surgery Date:
Surgical Procedure:	Anesthesia Type:
Chief Complaint:	
History of Present Illness:	
Allergies:	

Past Medical/ Surgical History:

- ICD  Pacemaker  Congestive Heart Failure  Coronary Artery Disease  Arrhythmia  Myocardial Infarction
  - Aortic Stenosis  Significant Valvular Disorder  Heart Murmur
  - Asthma  COPD  Sleep Apnea  O2 Dependent
  - Diabetes  Insulin Dependent  Non-insulin Dependent
  - Hypertension  Hyperlipidemia  Hyperthyroidism  Hypothyroidism  GERD  Abnormal Bleeding/ Bruising
  - CVA  TIA  DVT  Pulmonary Embolism  Coagulopathy/ Anticoagulation  Seizure Disorder  Dementia
  - ESRD  Dialysis  Liver Disease  Kidney Disease  Prior Anesthetic Complications
  - Hepatitis  Transplant  Other: \_\_\_\_\_
  - Patient Surgical History: \_\_\_\_\_
- Tobacco Use: \_\_\_\_\_ Alcohol Use: \_\_\_\_\_ Drug Use: \_\_\_\_\_
- Medications: \_\_\_\_\_

Physical Examination

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_ Respiration Rate: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ BMI: \_\_\_\_\_

Constitutional	<input type="checkbox"/> WNL- If not: Explanation
HEENT	<input type="checkbox"/>
Neck	<input type="checkbox"/>
Cardiac	<input type="checkbox"/>
Pulmonary	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>
Extremities	<input type="checkbox"/>
Neuro	<input type="checkbox"/>
Skin	<input type="checkbox"/>
Other	<input type="checkbox"/>
EKG, Labs, Imaging, Comment on abnormal:	
Assessment/ Plan:	

After examining the patient and reviewing the preoperative data, I find this patient to be medically stable for the proposed surgery and appropriate for care in an ambulatory center versus a hospital.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ License Number: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Surgery Pre Op Review

I have reviewed this History and Physical and examined the patient for changes since its performance. Based upon my assessment no changes have occurred and the patient may proceed with the planned procedure.

Surgeon's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_