

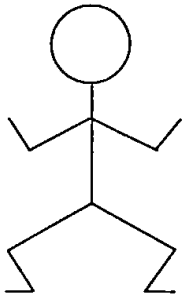
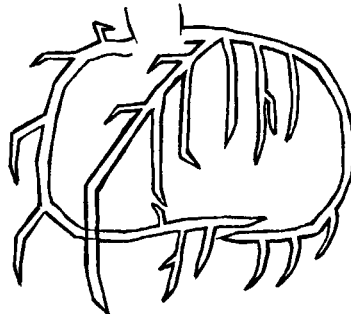
History and Physical Examination

Cardiothoracic Surgery

Reason for Admission			Age
			Sex
History of Presenting Illness			
CCS Class			NYHA Class
Risk Profile			Comments
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hyperlipidemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Family History	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of Ethanol intake	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Previous MI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
CHF	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Allergies <i>(Please document nature of reaction)</i>			
Sensitivities			
Medications			
Past Medical History			
Past Surgical History			
Review of Systems			Description
Neurological	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Respiratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Genitourinary	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Endocrine Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Peripheral Vascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

History and Physical Examination

Cardiothoracic Surgery

General Apperance					
Vital Signs	HR	BP	RR	Temp	Wt
CNS					
CVS					
RESP					
GI					
GU					
Extremities Saphenous Veins Pulses 		Relevant Hemodynamics		Result of Angiogram 	
Results of					
Echo					
EST					
Other					
Clinical Impression					
Operation Proposed					
Date (yyyy-Mon-dd)	Print Name		Signature		Initials