Goldberg, Rosenstein, Khan & Forman, M.D., P.A.| Now in Partnership with Gastro Health
Phone 410-296-4415 • Fax 410-296-4417

*****NO BLOOD WORK OR EKG REQUIRED*****

Pre-op History and Physical Form

To Be Completed by Physician, Physician Assistant or Nurse Practitioner (**Requires Physician Signature**)

Patient Name: _____ DOB: _____ Procedure Date: _____

Scheduled Procedure: □ Colonoscopy □ EGD □ ERCP □ EUS Diagnosis: _____

GI Doctor: □ Andrew Rosenstein □ Aminur Khan□ Joshua Forman □ Jamie Walters Location: **x** Endo Center □ DDC

Physician to Complete: _____ Fax #: _____

Medical History/Review of Systems - Check Box if Applicable

Cardiovascular □ NONE
□ Hypertension
□ Angina/Chest Pain
□ MI / CAD
□ CHF
□Arrhythmia/Palpitations
□ Pacemaker/AICD
□Vascular Disease
□ CABG/Cardiac Surgery
□ Coronary Stent
□ Poor Exercise Tolerance
□ PVD
□ Other _____

Pulmonary □ NONE
□ Asthma
□ COPD/Emphysema
□ Smoking History
□ SOB
□ Sleep Apnea
□ CPAP
□ Cough
□ Wheezing
□ PND/Orthopnea
□ URI
□ Other _____

Neuromuscular □ NONE
□ TIA or Stroke
□ Seizures
□ Cerebrovascular Disease
□ Dementia
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Psychiatric Disorder
□ Neuromuscular Disease
□ Syncope
□ Other _____

GI Endocrine □ NONE
□Hiatal Hernia
□ Reflux
□ Hepatitis - Type _____
□ Cirrhosis
□ Thyroid Disease
□ Recent Steroid Use
□ Obesity
□ Diabetes: □Type 1 □ Type 11

Hematologic □ NONE
□ Anemia
□ Sickle Cell Disease/Trait
□ Bleeding Disorder
□ Cancer
□ Chemotherapy

GYN/GU Renal □ NONE
□ Pregnant
□ LMP _____
□ Kidney Disease
□ UTI
□ Other _____
□ Apnea

Anesthesia Airway □ NONE
□ Family History of Anesthesia Problems
□ Previous Anesthesia Complications
□ Congenital Anomaly
□ Other _____

Social History □ NONE
□ Smoking
□ Alcohol
□ Drugs

Additional Comments on Medical History:

Allergies:

Medications:

Past Surgical History:

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Please return forms immediately upon completion to FAX # 410-296-4417

Patient Name: _____ D.O.B: _____

Physical Exam:

Height:_____ Weight: _____Pulse: _____ BP: _____ Resp: _____ Temp: _____

HEENT: ☐ PERLLA ☐ EOMI ☐ No Lymphadenopathy ☐ No JVD ☐ O/P MNL ☐ Thyroid WNL ☐WNL
Abnormal:

CARDIOVASCULAR: ***☐RRR S1/S2 ☐S3 ☐S4***
Abnormal:

PULMONARY: ☐ Lungs CTA B/L
Abnormal:

GI: ☐ ABD Benign - Normal Active Bowel Sounds ☐ No Hepatomegaly
Abnormal:

EXTREMITIES: ☐ No Clubbing ☐ No Cyanosis ☐ No Edema
Abnormal:

MUSCULOSKELETAL: ☐ Normal Muscle Tone ☐ Normal Strength
Abnormal:

NEUROLOGICAL: ☐CN II-XII ☐ DTR Intact and Equal Bilateral ☐ Normal Mental Status
Abnormal:

GENITAL/RECTUM: ☐ Deferral ☐ No Masses ☐Heme Negative
Abnormal:

ASSESSMENT: ☐ Medical condition optimized, further testing not recommended. Patient may proceed with procedure.

☐ Further evaluation needed as follows: _____

_____

_____

Nurse Practitioner Name (Print): _____ Date: _____

Physician Name (Print): _____ Contact Number: _____

Physician Signature: _____ Date: _____

Failure to receive forms **at least 5 business days prior** to surgical date may result in cancellation of the procedure.