



060

Mount Sinai

PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

Planned Surgical Procedure: _____

Date Planned Surgery: _____ Hospital/Location of Surgery: _____

Attending Surgeon: _____

History of Present Illness: _____

All relevant preoperative PMH listed below was reviewed and found to be negative unless specified below.

Table with columns: Past Medical History, Cardiac History, Social History, Allergies/Reaction, Past Surgical History. Includes rows for CKD Stage, Pulmonary Hypertension, ETOH/Drinks per week, etc.

Other Relevant History section including Pregnant, Birth Control, Family Hx, and Other.

Table with columns: Medications, Dose, Continue? (Yes/No).

61315 (05/18)



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Review of Systems: All systems were reviewed and found to be negative except as per HPI or specified below:
(circle all that apply)

System	Symptoms	Negative
Gen	weight loss or gain, fatigue, fever or chills, weakness, trouble sleeping	<input type="checkbox"/>
CVS	chest pain, irregular heartbeat, SOB, difficulty breathing at night, swollen legs or feet	<input type="checkbox"/>
Resp	chronic dry cough, coughing up blood, wheezing or night sweats	<input type="checkbox"/>
HEENT	double or blurred vision, loss of hearing, nosebleeds, dentures	<input type="checkbox"/>
Heme	bleeding tendency or clotting tendency	<input type="checkbox"/>
GI	nausea, vomiting, diarrhea, black stools, abdominal pain	<input type="checkbox"/>
GU	difficult urination, burning with urination, blood in the urine	<input type="checkbox"/>
Vascular	calf pain with walking, leg cramping	<input type="checkbox"/>
Musculoskeletal	muscle or joint pain, stiffness, back pain, redness of joints, swelling of joints, trauma	<input type="checkbox"/>
Neuro	headache, dizziness, fainting, LOC, memory loss	<input type="checkbox"/>
Psych	nervousness, stress, depression, memory loss	<input type="checkbox"/>
Other		<input type="checkbox"/>

Physical Exam

BP _____ HR _____ T _____ RR _____ HT _____ WT _____ BMI _____ SaO2 _____

Check for normal exam, indicate abnormal findings and describe

General	<input type="checkbox"/> A&O x 3 <input type="checkbox"/> NAD
ENT	<input type="checkbox"/> throat clear
Neck	<input type="checkbox"/> no bruits <input type="checkbox"/> no JVD
CV	<input type="checkbox"/> RRR <input type="checkbox"/> no murmurs, rubs, gallops
Lungs	<input type="checkbox"/> CTA bilat. <input type="checkbox"/> no wheezes or rhonchi <input type="checkbox"/> nl resp. effort
Abd	<input type="checkbox"/> soft <input type="checkbox"/> ND/NT
Ext	<input type="checkbox"/> no clubbing, cyanosis, or edema <input type="checkbox"/> nl pulses
Neuro	<input type="checkbox"/> nl and equal strength
Other	

Test	Date	Results
CXR		
EKG		
Echo		
Stress Test		
Cardiac Cath		
Other Studies		



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Surgical Risk For Planned Procedure:

Risk of Planned Surgical Procedure (low, intermediate, high)

High risk cardiac conditions (Unstable angina, decompensated CHF, significant arrhythmia or significant valvular disease)

Cardiac Risk Assessment:

Determination of risk - Please use whichever risk stratification tool (e.g. RCRI, Gupta, NSQIP) that is most appropriate to this patient and this procedure.

RCRI Risk Score: _____ (High-risk surgical procedure, ischemic heart disease, heart failure, CVA/TIA, DM on Insulin, chronic renal insufficiency)

The patient has a (low / elevated) risk of a major cardio vascular event.

If elevated, please specify patient's Metabolic Equivalents (METs): >4 <4
 Unable to assess.

Non-Cardiac Risk Assessment: _____

Further testing indicated: Yes No

Further consults indicated: Yes No

Overall Medical Risk for Surgery: Optimized Not Optimized Optimized Pending _____

Recommendations: _____



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PGY/NP/PA Name (printed) _____ Date _____ Time _____

PGY/NP/PA Signature _____ Contact # _____

I have interviewed and examined the patient. I have confirmed the plan of care with the Resident/NP/PA.

Attending Signature _____ Date _____ Time _____

Print Name _____

- I have reviewed the Pre-Operative Medical Assessment and acknowledge its findings.
- I have discussed the alternative treatment options and the potential risks and anticipated benefits of the planned procedure with the patient and/ or his/her family in light of the POMA findings.
- All questions have been answered.

Reviewed by: Attending Surgeon's Signature _____ Date _____ Time _____

Print Name _____