Swedish Cardiac Surgery Consultation (History and Physical)

Name of Patient: _____ Age: _____ MRN:_____

Name of closest relative or friend: _____ Relationship: _____

Primary care physician:_____ Phone No. (_____)_____

Cardiologist:_____ Phone No. (_____)_____

Dentist:_____ Phone No. (_____)_____

1. Does anyone have "Durable Power of Attorney" for you? Yes No

   Who?_____

   Relationship:_____

2. Do you have a completed "Living Will" or "Advanced Medical Directive"? Yes No
3. Where will you be staying when released from the hospital? _____

   If home, who can stay with you for several days after release from the hospital? _____

   If no one can stay with you for several days, you should consider a short stay in a skilled nursing facility after discharge from the hospital.

4. Do you need to consider a skilled nursing facility? Yes No
5. What **type of surgery** do you think you have been referred for? (*Circle all that apply*).

   Coronary Artery Bypass Aortic Valve Mitral Valve Tricuspid Valve

   Congenital Heart Defect Atrial Septal Defect Atrial Fibrillation / MAZE Procedure

   Ascending Aorta Repair/Replacement Other (Please explain)_____

6. Have you had heart surgery before? Yes No When & Where: _____
7. Have you ever had a heart attack(s)? Yes No When:_____
8. Have you ever been told you have "heart failure"? Yes No When:_____
9. Have you had a recent cardiac catheterization? Yes No When?_____

   At which hospital & city?_____

10. What is your Chief Complaint, the reason why you are here today?_____
11. What symptoms are related to your condition?

    None Fatigue Chest Pain Shortness of Breath Decreasing Stamina Palpitations Ankle Swelling

    Other symptoms?_____

12. How long have you had symptoms?_____
13. How severe are the symptoms? Minimal Mild Moderate Severe
14. Have the symptoms worsened recently? Yes No
15. When, or with what activity, do the symptoms occur?_____
16. What, if anything, make the symptoms worse?_____
17. What, if anything, improves the symptoms?_____

_____
Patient Name

Past Medical History

Please list the medications you are currently taking, the dose, how often, and for what condition.

Medication	Dose	How often?	For what condition?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

Have you taken, or been given, any of the following medications in the last week? *(Please circle all that apply.)*

Aspirin	Coumadin (Warfarin)	Aggrenox (ASA with dipyridamole)
Aleve	Plavix (clopidogrel)	Effient (prasugrel)
Ibuprofen	Ticlid (ticlopidine)	Xarelto (rivaroxaban)
Motrin	Pradaxa (dabigatran)	Eliquis (apixaban)

Other pain or arthritis medications? _____

When was the last dose? _____

List any medications or agents *(e.g. iodine)* to which you have known allergies or serious side effects.

Medication or Agent	**Allergy or Side Effect (***rash, difficulty breathing, nausea***)**
1.	
2.	
3.	
4.	

_____
Patient Name

Previous Surgeries

Surgery	Date	Where? *(Hospital and City)*
1.		
2.		
3.		
4.		
5.		
6.		

Previous major accidents, injuries, or illnesses requiring hospitalization

Description or name	Date	Where? *(Hospital and City)*
1.		
2.		
3.		
4.		
5.		

Chronic Illnesses *(e.g. diabetes, high blood pressure)*

Illness	How long have you had it?
1.	
2.	
3.	
4.	
5.	

Anesthesia History

1. Have you had general anesthesia before?	Yes No
2. Have you had any problems with anesthesia in the past?	Yes No If yes, please explain:

Tobacco, alcohol and substance use history *(Answer honestly, these habits may affect your recovery.)*

1. Do you smoke or have a history of smoking?	Yes No
2. Have you quit smoking?	Yes No Quit date:
3. How many packs per day did or do you smoke?	½ pack per day or less 1½ -2 packs per day ½-1 pack per day 2 or more packs per day 1-1½ packs per day
4. How many years have you smoked?	years
5. Do you use or have a history of using other tobacco?	Yes No If yes, what type?
6. How often do you drink alcohol?	Never Less than 1 drink per week 2-7 drinks per week More than 8 drinks per week
7. Do you have a history of addiction or withdrawal to alcohol or other substances?	Yes No If yes, when?
8. Do you use recreational substances such as marijuana, cocaine, methamphetamines, etc?	Yes No If yes, when?

_____
Patient Name

Family History

Relative	Age	Age at Death	Cause of Death	History of illnesses? *(Please circle or write-in)*
1. Father				Diabetes High blood pressure Stroke Cancer Lung disease Bleeding disorder Heart Disease (heart attack or sudden death before 55 yo)
2. Mother				Diabetes High blood pressure Stroke Cancer Lung disease Bleeding disorder Heart Disease (heart attack or sudden death before 65 yo)
3. Siblings 1				
2				
3				
4				
4. Children 1				
2				
3				
4				

Social History *(Please circle or write-in)*

Marital Status	Single	Married	Domestic Partner	Divorced	Widowed
Employment Status	Working	Home Caretaker	Retired	Unemployed	Disabled
Present or last occupation					
Hobbies or interests					

Review of Systems *(Please circle your response and provide date if requested)*

Constitutional Symptoms

Fevers .....Yes No
Profuse, severe night sweats .....Yes No
Large, unexplained weight loss .....Yes No
Beginning or present colds or flu .....Yes No

Heart

Irregular heart beat or atrial fibrillation ……Yes No
Wake up with severe shortness of breath …….Yes No
Shortness of breath with minimal exertion ……..Yes No
Cannot lie flat without severe shortness of breath……Yes No
History of Rheumatic Fever …….Yes No
*MD Notes*_____
_____

Veins of Legs (not arteries)

Previous vein stripping .....Yes No
Previous operation on veins .....Yes No
History of thrombophlebitis (blood clots in leg veins) Yes No
Varicose veins .....Yes No
*MD Notes*_____

Vascular system (arteries)

Carotid artery (neck) operations or blockages….Yes No
Recent carotid artery (neck) ultrasound or scan...Yes No
Known aneurysms (enlargements of arteries) …..Yes No
Previous abdominal aortic surgery……Yes No
Previous leg artery bypass…… ……Yes No
Problems with arm or hand arteries…..……Yes No
Severe cramping pain in calves when walking ….Yes No
Previous amputations…….…. ..Yes No
Previous or present ulcers on ankles or feet….....Yes No

*MD Notes*_____

Head and Neck (HEENT)

Blindness……Yes No
Sinus Infections……..Yes No
Recent extensive dental work…….Yes No
Recent tooth abscesses or infections……..Yes No
Neck or jaw masses or cancer……Yes No
If yes, when _____
*MD Notes*_____

_____
Patient Name

Chest Wall

Chest wall defects or masses…… Yes No
Previous chest wall surgery……Yes No
Previous breast surgery……Yes No
Breast cancer……Yes No
If yes, when_____
Chest wall radiation……Yes No
*MD Notes*_____

Lungs (Respiratory)

Emphysema……..Yes No
Asthma……..Yes No
Taken steroids or prednisone for lungs in the past.....Yes No
Wheezing .....Yes No
History of Tuberculosis .....Yes No
History of pneumonia .....Yes No
If yes, when?_____
History of lung cancer .....Yes No
If yes, when? .....
Previous lung surgery……Yes No
Recent coughing up of blood in sputum……Yes No
Been seen by a lung specialist……...Yes No
Previous lung function studies in last year……Yes No
Use home oxygen…….……Yes No
Diagnosis of sleep apnea……...Yes No
Use CPAP or biPAP machine……...Yes No
*MD Notes*_____

Liver and Gallbladder

Hepatitis or yellow jaundice .....Yes No
Cirrhosis or scarred liver .....Yes No
Liver failure .....Yes No
Previous liver biopsy .....Yes No
Previous liver surgery .....Yes No
Gallbladder removed .....Yes No
Gallstones present now .....Yes No
Recent gallbladder trouble .....Yes No
Other problems pertaining to your liver?_____
MD Notes _____

Stomach and Intestines.....

Esophageal problems or difficulty swallowing? .....Yes No
Hiatal hernia .....Yes No
Esophageal strictures .....Yes No
Previous esophageal surgery .....Yes No
Recent ulcer disease of stomach or intestine .....Yes No
Bleeding ulcers or blood in stool .....Yes No
Stomach or intestinal surgery .....Yes No
Inflammatory bowel disease .....Yes No
Colitis .....Yes No
Diverticulitis .....Yes No
Stomach or intestinal cancer .....Yes No
If yes, date of cancer_____
Bleeding hemorrhoids .....Yes No
Other gastrointestinal problems?_____
*MD Notes*_____

Kidneys and Urinary Tract

Kidney infections……...Yes No
Kidney or bladder cancer……...Yes No
If yes, when_____
Kidney insufficiency……..Yes No
Kidney failure/Dialysis……..Yes No
Kidney stones……..…Yes No
Kidney or bladder tumor (not cancer)..……..Yes No
Recent bladder infection……Yes No
Recent blood in urine…… Yes No
Previous prostate surgery……Yes No
Prostate cancer……Yes No
If yes, when_____
Testicular masses or cancer ……...Yes No
If yes, when_____
Other urinary tract problems?_____
*MD Notes*_____

Blood (Hematologic)

Received blood transfusions……..Yes No
Jehovah's Witness……..Yes No
Willing to accept blood or blood products if medically necessary to save your life?.....Yes No
Bleeding abnormalities (difficulty clotting)……...Yes No
Family history of Bleeding abnormalities……..Yes No
Leukemia……Yes No
If yes, when_____
Lymphoma…….....Yes No
If yes, when_____
*MD Notes*_____

Endocrine

Hypothyroid……..Yes No
Hyperthyroid……Yes No
Previous thyroid surgery……...Yes No
Thyroid cancer……..Yes No
If yes, when_____

Abnormally high blood calcium levels……Yes No
Parathyroid problems……Yes No
Previous parathyroid surgery……Yes No
Adrenal gland problems or family history……....Yes No
Previous adrenal surgery……...Yes No
Pituitary problems or surgery……Yes No
Hormone or steroid replacement *(e.g. estrogen)*…Yes No
Diabetes……Yes No
Insulin injections……...Yes No
How often do you check your glucose at home?
_____
What is your usual blood glucose range?
_____
Which doctor manages your diabetes?
_____
Other endocrine problems?_____
*MD Notes*_____

_____
Patient Name

Musculoskeletal

Arthritis requiring medical attention .....Yes No
Joint replacements .....Yes No
Marked weakness of a single arm or leg .....Yes No
Difficulty walking .....Yes No
Use a walker .....Yes No
Previous low back surgery or problems .....Yes No
Any spine problems of the neck .....Yes No
Any muscular diseases or family history……..Yes No
*MD Notes*_____
_____

Neurologic

Migraines .....Yes No
Stroke .....Yes No
TIA (transient ischemic attack) .....Yes No
Temporary paralysis of an arm or leg .....Yes No
Temporary severe slurring or loss of speech .....Yes No
Temporary loss of vision in a single eye .....Yes No
Aneurysm or bleeding into brain .....Yes No
Brain injury or trauma .....Yes No
Seizure disorder .....Yes No
Fainting or black out spells within past year? .....Yes No
Marked change in memory or mood .....Yes No
*MD Notes*_____
_____

Pscyhiatric

Ever been on psychiatric medications ……Yes No
Any history of psychiatric illnesses…….Yes No
Extreme irritability……..Yes No
Overwhelming nervousness or anxiety……Yes No
History of depression?.....Yes No
*MD Notes*_____
_____

Infectious Disease History

Heart valve infection …….....Yes No
If yes, when_____
Tuberculosis……...Yes No
Syphilis……..Yes No
HIV…….……...Yes No
Diphtheria……..Yes No
Malaria……...Yes No
Yellow Fever……..Yes No
Other:_____
*MD Notes*_____
_____

*Additional MD Notes:*_____
_____
_____

Vital Signs (*to be completed by nurses)*

Blood Pressure	Pulse	SaO2	Temp	Weight	Height
Right arm _____/_____	_____bpm	_____%	_____F	_____lbs	_____in
Left arm _____/_____	_____			_____kg	_____BMI

Usual BP _____/_____
Five meter walk results: Time 1: _____ (secs) Time 2: _____(secs) Time 3: _____(sec)

_____
MD Signature Date