Hudson Yards Surgery Center Pre-Operative Medical Evaluation
450 West 31st 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	☐ WNL- If not: Explanation
HEENT	☐
Neck	☐
Cardiac	☐
Pulmonary	☐
Gastrointestinal	☐
Extremities	☐
Neuro	☐
Skin	☐
Other	☐
EKG, Labs, Imagining, 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: _____