

History and Physical Exam Standards *(Updated may 2012 Pfeifer, Slawski)*

Medical Staff Divisional Policy MSP.0001 Froedtert Hospital requirements for preoperative H+P documentation:

An H&P which is performed up to or no more than 30 days before the procedure may be utilized provided that a copy is filed in the patient's medical record. Unless the operating surgeon states in writing or it is evident that an emergency exists and delay would constitute a hazard to the patient, surgery shall not be performed until the history and physical examination, any indicated diagnostic tests, and a pre-operative diagnosis have been recorded.

The history and physical examination report must be age-appropriate and include:

- 1. The patient's name, sex, address, date of birth and authorized representative if any.*
- 2. The reason(s) for admission for care, treatment or services (i.e. chief complaint).*
- 3. A pertinent health history, containing a description of present illness, past history of illness and pertinent family and social history.*
- 4. Assessment, which should include pertinent elements of physical examination, and pertinent assessments of psychological, pain, social, nutrition and hydration status, and functional status. For patients receiving end of life care, the assessment should also include social, spiritual and cultural variables.*
- 5. Positive and negative findings resulting from a review of systems.*
- 6. The diagnosis, diagnostic impression or conditions.*
- 7. Conclusions or impressions drawn from the medical history and physical exam.*
- 8. A complete list of current medications on admission, including OTC and herbal should be in the H&P or available in the electronic medical record.*
- 9. When appropriate, time spent counseling/coordinating care.*
- 10. The date of the history and physical examination must be recorded and the entry authenticated by the author.*

FMLH Preoperative Evaluation/ Documentation Guidelines:

Please include the following information in the History and Physical exam documentation, as pertinent. **“Cleared for surgery” is not considered adequate.**

Cardiovascular Disease

- It is suggested that the American College of Cardiology/ American Heart Association Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery be used for preoperative evaluation (www.acc.org) and assessment of need for beta blockade be included. All patients on chronic beta blockers should have these medications continued throughout the perioperative period unless there is a specifically documented contraindication
- Please describe any history of cardiovascular disease and list patient's cardiologist/electrophysiologist
- CAD: reports of most recent stress test or cardiac catheterization, include type of stent (bare metal, drug-eluting), history of MI (date), and recommendations for perioperative management
- CHF: reports of most recent echocardiogram and recommendations for perioperative management
- Implanted cardiac devices: type (single-chamber/dual-chamber/biventricular pacemaker, AICD), most recent status check and history of discharges (for AICDs), and any history of cardiac arrest (date)
- Dysrhythmias/conduction system disease: type and dates of occurrence and therapies, reports of most recent event monitor and other cardiac studies, and recommendations for perioperative management including anticoagulation
- Valvular heart disease: reports of most recent echocardiogram, cardiac catheterization, and type of prosthesis (porcine vs. mechanical) with date of placement;

Pulmonary Disease – please describe any prior history of pulmonary disease with dates of any previous hospitalizations/intubations, reports of most recent PFTs and ABGs, amount of rescue inhaler use. Please specifically address OSA/CPAP, BiPAP use.

Hematologic Disease – please describe any prior history of bleeding, clotting or other heme disorders, prior transfusion reactions. Specifically address anticoagulant use and plans for perioperative management/bridging. It is suggested that the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines be used for management of anticoagulants

Anesthesia- please list any history of anesthetic complications and include anesthesia records

Endocrine Disease-describe history of endocrine disease and perioperative management plan

Renal Disease- for patients with CKD: include stage, baseline GFR/creatinine; determined cause; include location and schedule of outpatient dialysis and type (peritoneal or hemodialysis); list nephrologist's name