

Patient Name: _____

D.O.B. _____

Surgeon: _____

B.O.S.S.
840 Winter Street
Waltham, MA, 02451
781-895-4901
FAX FORM TO; 781-895-4902

PAST HISTORY		NEG	COMMENT IF POSITIVE
CARDIAC	Infarction, failure, murmur, arrhythmia, palpitations, hypertension, angina	<input type="checkbox"/>	
PULMONARY	bronchitis, emphysema, asthma, pneumonia, sputum, TB	<input type="checkbox"/>	
CMS	seizures, stroke, migraine, MS	<input type="checkbox"/>	
KIDNEY	infections, failure	<input type="checkbox"/>	
ENDOCRINE	diabetes, thyroid, adrenal	<input type="checkbox"/>	
LIVER	hepatitis, failure	<input type="checkbox"/>	
GI	hiatal, hernia, colitis, Crohn's	<input type="checkbox"/>	
GYN/GU		<input type="checkbox"/>	
BONE/JOINT	arthritis	<input type="checkbox"/>	
ENT	nose bleeds, croup, upper airway	<input type="checkbox"/>	
EYE	glaucoma	<input type="checkbox"/>	
FAMILY HISTORY OF BLEEDING TENDENCY		<input type="checkbox"/>	
PAST SURGERY		<input type="checkbox"/>	

DRUGS TAKEN PAST 6 MONTHS		NEG	
CARDIAC	diuretics, antihypertensives	<input type="checkbox"/>	
PULMONARY	bronchodilators	<input type="checkbox"/>	
CNS	anticonvulsants, tranquilizers	<input type="checkbox"/>	
ENDOCRINE	insulin, steroids, thyroid	<input type="checkbox"/>	
BONE/JOINT	anti-inflammatory	<input type="checkbox"/>	
EYE	eye drops	<input type="checkbox"/>	
ALCOHOL/DRUG ABUSE		<input type="checkbox"/>	

DRUG ALLERGIES

DRUG SENSITIVITY

PHYSICAL EXAMINATION		NEG	
NEUROLOGICAL		<input type="checkbox"/>	
HEENT	eyes	<input type="checkbox"/>	
	ears, nose	<input type="checkbox"/>	B/P
	mouth, throat	<input type="checkbox"/>	HT.
	neck	<input type="checkbox"/>	WT.
CHEST	respiratory	<input type="checkbox"/>	
	heart	<input type="checkbox"/>	
	breasts	<input type="checkbox"/>	
ABDOMEN		<input type="checkbox"/>	
PELVIC		<input type="checkbox"/>	
MUSCULOSKELETAL		<input type="checkbox"/>	

COMMENTS: Special Lab Orders-Pre-Op Order

- no contradiction-cleared for surgery
- not cleared for surgery

