



Doctors of Thoracic Surgery

PATIENT LABEL

SURGEON: \_\_\_\_\_

DATE OF SURGERY: \_\_\_\_\_

Pre-Operative Evaluation			
Height: _____(cm)	Weight: _____(kg)	Wt loss over past 3 months? (Enter "0" if none) _____(kg)	
Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids <input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive Heart Failure(CHF) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coronary Artery Disease (CAD) <input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease (PVD) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prior Cardiothoracic Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No			
Preoperative Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes → When: <input type="checkbox"/> ≤ 6 months <input type="checkbox"/> > 6 months		
Preop Thoracic Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes → <input type="checkbox"/> Same disease, ≤ 6 months <input type="checkbox"/> Same disease, > 6 months <input type="checkbox"/> Unrelated disease, ≤ 6 months <input type="checkbox"/> Unrelated disease, > 6 months		
Cerebrovascular History: <input type="checkbox"/> No CVD history <input type="checkbox"/> Transient Ischemic Attack (TIA) <input type="checkbox"/> Cerebrovascular Accident (CVA)			
Pulmonary Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable/Not documented			
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes → Type of therapy: <input type="checkbox"/> None <input type="checkbox"/> Diet Only <input type="checkbox"/> Oral <input type="checkbox"/> Insulin <input type="checkbox"/> Other subcutaneous medication <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
On Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	Creatinine level measured <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes → Last creatinine level _____	
Hemoglobin level measured <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes → Last hemoglobin level _____		
COPD <input type="checkbox"/> Yes <input type="checkbox"/> No	Interstitial Fibrosis <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Cigarette smoking:</b> <input type="checkbox"/> Never smoked <input type="checkbox"/> Past smoker (stopped >1 month prior to operation) <input type="checkbox"/> Current smoker <input type="checkbox"/> Unknown			
If 'Past smoker' or 'Current Smoker' →	Pack Year Known or can be estimated <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes → Pack-Years - _____	
<b>Pulmonary Function Tests performed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No →	PFT Not Performed Reason <input type="checkbox"/> Not a Major Lung Resection <input type="checkbox"/> Tracheostomy or Ventilator	<input type="checkbox"/> Never smoked, no Lung Dx <input type="checkbox"/> Urgent or Emergent Status	<input type="checkbox"/> Pt. Unable to perform
If Yes →	<b>FEV1 test performed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	If Yes → <b>FEV1 % predicted:</b> _____	
	DLCO test performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	If Yes → DLCO % predicted: _____	
<b>Zubrod Score:</b> <input type="checkbox"/> Normal activity, no symptoms <input type="checkbox"/> Symptoms, fully ambulatory <input type="checkbox"/> Symptoms, in bed ≤ 50% of time <input type="checkbox"/> Symptoms, in bed >50% but <100% <input type="checkbox"/> Bedridden <input type="checkbox"/> Moribund			

COMPLETED BY: \_\_\_\_\_

SEE OVER IF CANCER SURGERY

(PLEASE PRINT)

DATE: \_\_\_\_\_

**Pre-treatment Lung cancer staging- to be completed if lung cancer documented AND lung resection performed.**

**Lung Cancer:**  Yes  No

**If Yes→ Clinical Staging Done**  Yes  No

<b>If Yes→</b>	Pre-Op Positive Tissue diagnosis Obtained: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Clinical Staging Methods : Choose all that apply ↓		
	Bronchoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	EBUS <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	EUS <input type="checkbox"/> Yes <input type="checkbox"/> No	Mediastinoscopy/Chamberlain <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PET or PET/CT <input type="checkbox"/> Yes <input type="checkbox"/> No	CT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	VATS <input type="checkbox"/> Yes <input type="checkbox"/> No	Laparoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Brain MRI <input type="checkbox"/> Yes <input type="checkbox"/> No	Brain CT Scan <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Needle Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Lung CA Tumor Size:  ≤ 2 cm  >2cm ≤ 3cm  >3cm ≤ 5cm  > 5cm ≤ 7cm  >7cm  Unknown

Invasion of Adjacent Structures:  Yes  No

<b>If Yes→</b>	Choose all Locations that apply: ↓		
	Visceral Pleura <input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Wall or Parietal Pleura <input type="checkbox"/> Yes <input type="checkbox"/> No	Diaphragm <input type="checkbox"/> Yes <input type="checkbox"/> No
	Phrenic Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Pericardium <input type="checkbox"/> Yes <input type="checkbox"/> No	Main Bronchus <input type="checkbox"/> Yes <input type="checkbox"/> No
	Obstructive Atelectasis or Pneumonitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Separate Nodule(s), same lobe <input type="checkbox"/> Yes <input type="checkbox"/> No	Mediastinum <input type="checkbox"/> Yes <input type="checkbox"/> No
	Heart <input type="checkbox"/> Yes <input type="checkbox"/> No	Great Vessels <input type="checkbox"/> Yes <input type="checkbox"/> No	Trachea <input type="checkbox"/> Yes <input type="checkbox"/> No
	Recurrent Laryngeal Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Esophagus <input type="checkbox"/> Yes <input type="checkbox"/> No	Vertebral Body <input type="checkbox"/> Yes <input type="checkbox"/> No
	Carina <input type="checkbox"/> Yes <input type="checkbox"/> No	Separate Nodule(s), different lobe <input type="checkbox"/> Yes <input type="checkbox"/> No	

Lung CA Nodes:	<input type="checkbox"/> N0 No regional lymph node metastasis	<input type="checkbox"/> N1 Metastasis in ipsilateral peribronchial or hilar and intrapulmonary nodes. Includes direct extension
	<input type="checkbox"/> N2 Metastasis in ipsilateral mediastinal and/or subcarinal lymph nodes	<input type="checkbox"/> N3 Metastasis in contralateral mediastinal or contralateral hilar nodes, ipsilateral or contralateral scalene or supraclavicular nodes
Lung CA Metastases:	<input type="checkbox"/> M0 No distant metastasis	<input type="checkbox"/> M1 Distant Metastasis

**Pre-treatment esophageal cancer staging- to be completed if esophageal cancer documented AND esophageal resection performed.**

**Esophageal Cancer:**  Yes  No

**If Yes→ Clinical Staging Done**  Yes  No

<b>If Yes→</b>	Clinical Staging Method(s) and Results: Choose all that apply ↓		
	Bronchoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	EBUS <input type="checkbox"/> Yes <input type="checkbox"/> No	EUS <input type="checkbox"/> Yes <input type="checkbox"/> No
	Mediastinoscopy / Chamberlain <input type="checkbox"/> Yes <input type="checkbox"/> No	PET or PET/CT <input type="checkbox"/> Yes <input type="checkbox"/> No	CT <input type="checkbox"/> Yes <input type="checkbox"/> No
	VATS <input type="checkbox"/> Yes <input type="checkbox"/> No	EGD <input type="checkbox"/> Yes <input type="checkbox"/> No	Laparoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No
	Endoscopic Mucosal Resection <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No	

Esophageal Tumor:	<input type="checkbox"/> T0 No evidence of primary tumor	<input type="checkbox"/> Tis High grade dysplasia	<input type="checkbox"/> T1 Tumor invades lamina propria, mucosa or submucosa
	<input type="checkbox"/> T2 Tumor invades muscularis propria	<input type="checkbox"/> T3 Tumor invades adventitia	<input type="checkbox"/> T4 Tumor invades adjacent structures

Clinical Diagnosis of Nodal Involvement:  Yes (N1, N2 or N3)  No

Esophageal CA Metastases:  M0  
No Distant Metastasis  M1  
Distant Metastasis