

McLaren Print System Order

Order No: 55280 Reprint Previous Order No: 5557  
Order Date: 2020-07-09  
User: MICHELLE GALATI  
Phone: 5867254604

Ship Location: McLaren Womens Health Chesterfield  
51086 Fairchild Rd  
Chesterfield, Michigan 48051

Forms

Quantity: 100  
Paragon Dept No: 72000  
Dept Name: McLaren Womens Health Chesterfield  
Company Number: 810

Order Total Price: 22.60

Item Number: MM-17283  
Item Description: Pre-Operative Clearance Consultation  
Revision Date: 4/2008  
Print: 2 sided full color  
Paper: 28# Color Copy Text  
Size: 8.5 x 11  
Fold:  
Finish:  
Drill: None  
Misc Info:

McLaren Ambulatory Care Center

PRE-OPERATIVE CLEARANCE CONSULTATION

\*requires completion of all highlighted areas

Requested by \_\_\_\_\_  M.D. or  D.O. Date \_\_\_\_\_

Reason \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

Past Medical History (check if present) or  NONE

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Type I
<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> GERD	<input type="checkbox"/> Type II
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> CVA	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Murmur	<input type="checkbox"/> Transient Ischemic Attack	<input type="checkbox"/> Cancer
<input type="checkbox"/> Pectus/MI/ICD	<input type="checkbox"/> Seizures	<input type="checkbox"/> Chronic Kidney Disease
<input type="checkbox"/> COPD		<input type="checkbox"/> Bleeding Disorders

\_\_\_\_\_ Fragrances  
\_\_\_\_\_ Delirium  
\_\_\_\_\_ Other

Past Surgical History \_\_\_\_\_

Social History  Occupation \_\_\_\_\_  Drugs \_\_\_\_\_

Smoking \_\_\_\_\_  Abuse (Psychosocial) \_\_\_\_\_

Alcohol \_\_\_\_\_

Family History  Diabetes  Bleeding Disorders  Malignant Hypertension

Heart Disease  Cancer

Review of Systems (check if present) or  None

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Altered Bowel Habits
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Constipation	<input type="checkbox"/> Altered Bladder Habits
<input type="checkbox"/> Cough	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dyspepsia/Dysphagia
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Anorexia/Weight Loss
<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Fatigue/Weakness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Light-Sensitivity	<input type="checkbox"/> Weakness in Extremities

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