MEDICAL CENTER

PRE-OPERATIVE CLEARANCE CONSULTATION*

***requires completion of all highlighted areas**

Request made by ______________________________ on ______________________
(Date)

Reason: ____

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____

Allergies: ____

Current Medications: ____

____

Past Medical History (check √ if present) or ☐ None

☐ Hypertension
☐ Coronary Artery Disease
☐ Myocardial Infarction
☐ Irregular Heart Beat
☐ Congestive Heart Failure
☐ Peripheral Vascular Disease
☐ Murmur
☐ Pacemaker/ICD
☐ COPD

☐ Asthma
☐ Tuberculosis
☐ GERD
☐ Hepatitis
☐ Ulcers
☐ CVA
☐ Transient Ischemic Attack
☐ Seizures

Diabetes Mellitus
☐ Type I
☐ Type II

Thyroid
☐ Hypothyroidism
☐ Hyperthyroidism

☐ Cancer
☐ Chronic Kidney Disease
☐ Bleeding Disorders

_______ Pregnancies
_______ Deliveries
☐ Other
____

Past Surgical History ____

____

Social History

☐ Occupation ____
☐ Smoking ______________________ ☐ Drugs ______________________
☐ Alcohol ______________________ ☐ Abuse (Psychosocial) ______________________

Family History

☐ Diabetes
☐ Heart Disease
☐ Bleeding Disorders
☐ Cancer
☐ Malignant Hyperthermia

Review of Systems
(check √ if present)
or
☐ None

☐ Chest Pain
☐ Shortness of Breath
☐ Cough
☐ Sore Throat
☐ Fever/Chills
☐ Dizziness

☐ Nausea/Vomiting
☐ Constipation
☐ Diarrhea
☐ Visual Disturbance
☐ Hearing Problems
☐ Light-headedness

☐ Altered Bowel Habits
☐ Altered Bladder habits
☐ Dyspepsia/Dysphagia
☐ Anorexia/Weight Loss
☐ Fatigue/Weakness
☐ Weakness in Extremities

Patient Name:

Date of Birth:

PHYSICAL EXAMINATION (Explain any abnormalities under "Other"):

Vital Signs: ☐ Reviewed ☐ Other ______________________

HEENT: ☐ Normal ☐ Other ______________________

Neck: ☐ Normal ☐ Other ______________________

Breast: ☐ Normal ☐ N/A ☐ Other ______________________

Thorax: ☐ Normal ☐ Other ______________________

Heart: ☐ Normal ☐ Other ______________________

Lungs: ☐ Normal ☐ Other ______________________

Abdomen: ☐ Normal ☐ Other ______________________

Genitalia: ☐ Normal ☐ N/A ☐ Other ______________________

Pelvic: ☐ Normal ☐ N/A ☐ Other ______________________

Rectal: ☐ Normal ☐ N/A ☐ Other ______________________

Extremities: ☐ Normal ☐ Other ______________________

Neuro: ☐ Normal ☐ Other ______________________

Pertinent Labs, X-Rays, EKG:

____

____

____

Findings:

____

____

____

Cleared for surgery: ☐ Yes ☐ No

Comments: ______________________

____

Report sent to: ______________________ Date/Time: ______________

Signature ______________________ Date/Time: ______________
Physician

Patient Name:

Date of Birth:

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