Pre-Operative History & Physical & Medical Clearance

PATIENT NAME: **DATE OF BIRTH**:

CHIEF COMPLAINT: Pre-op clearance for **BUNION** Surgery

HISTORY OF PRESENT ILLNESS:

FAMILY HISTORY: ☐ None Contributory **ALLERGIES:**________________________________

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CURRENT MEDICATIONS (list if any): ☐ None

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Vital Signs: **BP**_____/______ **P**_______ **R**_______ **T**________ **O2 Sat**________% **HT**________**WT**_______**lbs**

PAST MEDICAL HISTORY

Yes	No	
☐	☐	CVA, Stroke, TIA
☐	☐	Neurological Disease
☐	☐	Heart Disease/History of MI
☐	☐	Hypertension
☐	☐	Kidney Disease
☐	☐	GI Disease
☐	☐	Diabetes
☐	☐	Liver Disease
☐	☐	Pulmonary Disease
☐	☐	Smoking History
☐	☐	Bleeding Tendencies
☐	☐	Alcohol Abuse
☐	☐	Other

REVIEW OF SYSTEMS/PHYSICAL EXAM

WNL	
☐	Cardiovascular________________________
☐	Respiratory________________________
☐	Gastrointestinal________________________
☐	Genitourinary________________________
☐	Gynecological________________________
☐	Musculoskeletal________________________
☐	Endocrine________________________
☐	Neurological________________________
☐	Integumentary________________________

PREVIOUS SURGERY/HOSPITALIZATIONS (list): ☐**None**

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DIAGNOSIS:____

PLAN:____

THE ABOVE NAMED PATIENT IS MEDICALLY OPTIMIZED FOR THE PROPOSED SURGERY IN AN AMBULATORY SURGERY CENTER SETTING:

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Physician's Signature **Printed Physician's Name or Stamp**

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Date