MEDICAL EVALUATION AND CLEARANCE FORM

Patient's Name: _________________ DOB: ___________ Surgery Date:__________
Surgery Scheduled:

HISTORY AND PHYSICAL: Date:___________________
History of Present Illness: ____
____
Recent Hospitalizations (within 6 months): ___________________________________
Allergies: ____
Current Medications: ____
Medications to hold prior to surgery: _______________________________________

PAST HISTORY:
__CAD __AFIB __HTN __MI __ Stents BMS or DES __Pacemaker _AICD ___CVA
__COPD __Asthma Surgery History: ___________________________
__DM oral insulin diet ____

EKG INTERPRETATION (please send strip if available)

PHYSICAL EVALUATION: BP: HR:

Do you find the patient medically stable for the above surgery with LOCAL anesthesia and IV sedation in a free-standing facility? _______________________

Physician Signature: ________________________ Date: _____________________
Printed Name: _______________________ Phone: _________________________