



PRE-SURGICAL EVALUATION AND CLEARANCE

LABELED LEGIBLE EKG TAKEN WITHIN 6 MONTHS

Patient's Name _____ Sex: M F D.O.B. _____
Ophthalmic Diagnosis _____ Anesthesia Type _____
Proposed Procedure _____ Date of Surgery _____
Past Medical History _____

Past Surgical History

Current Medications

Allergies _____ Tobacco _____ Alcohol _____ Diet _____

Family History _____

PHYSICAL EXAMINATION: Vital Signs: BP. _____ P. _____ R. _____ T. _____ Ht. _____ Wt. _____

HEENT: _____

NECK: _____

CHEST: _____

HEART: _____

ABDOMEN: _____

EXTREMETIES: _____

NEUROLOGICAL: _____

DIAGNOSIS: _____

PERI-OPERATIVE RECOMMENDATIONS: _____

I believe this patient will satisfactorily tolerate the proposed procedure: _____ M.D.

Date: _____ Print Last Name and Phone # _____

PLEASE INCLUDE CLEAN LEGIBLE COPY OF MOST RECENT EKG AND ANY APPLICABLE LABS

If you have any trouble faxing this information, please call the Surgery Center Scheduling Office in Brentwood at: (631) 231-4949 Ext. #349 *Fax:* 631-951-2022.

