PRE-OPERATIVE MEDICAL EVALUATION
CAPE COD EYE SURGERY AND LASER CENTER
FAX TO:

Patient: _____ DOB: _____

Surgery Date:_____ Surgeon: _____

SURGICAL CLEARANCE REQUIREMENTS: Please see Surgical Clearance Requirements 1-3 on the back side of this form.

DIAGNOSIS/HISTORY OF PRESENT PROBLEM:

PAST HISTORY		NEG	IF POSITIVE- LIST COMMENTS
CARDIAC:	Infarction, failure, murmur, arrhythmia palpitations, hypertension, angina	☐	
PULMONARY:	Bronchitis, emphysema, asthma pneumonia, sputum, TB	☐	
CNS:	Seizures, stroke, migraine, MS	☐	
KIDNEY:	Infections, failure	☐	
ENDOCRINE:	Diabetes, thyroid, adrenal	☐	
LIVER:	Hepatitis, failure	☐	
FAMILY HISTORY OF BLEEDING TENDENCY:		☐	
PAST SURGERY:		☐	

DRUGS TAKEN IN THE PAST SIX MONTHS		NEG	OR	DRUG	DOSE	DISCONTINUED
CARDIAC:	Diuretics, antihypertensive beta blockers, digitalis	☐				
PULMONARY:	Bronchodilators	☐				
CNS:	Anticonvulsants, tranquilizers	☐				
ENDOCRINE:	Insulin, steroids, thyroid	☐				
BONE/JOINT:	Anti-inflammatory	☐				
EYE:	Eye drops	☐				
ALCOHOL/DRUG ABUSE:		☐				
FLOMAX:		☐				

DRUG ALLERGY/ SENSITIVITY	NEG	OR	DRUG	TYPE OF REACTION
	☐			

PHYSICAL EXAMINATION:		NEG
NEUROLOGICAL		☐
HEENT:	Ears, Nose	☐
	Mouth, throat	☐
	Neck	☐
CHEST:		
	Respiratory	☐
	Heart	☐
	Breasts	☐
ABDOMEN:		☐

BP

PULSE (reg/irreg)

THE ABOVE NAMED PATIENT IS CLEARED FOR SURGERY: Yes ☐ No ☐

COMMENTS: _____

_____

PHYSICIAN SIGNATURE: _____ DATE: _____

PRINTED PHYSICIAN NAME: _____

☐ CHECK THIS BOX TO ALLOW ANY SUBSEQUENT EYE SURGERY SCHEDULED WITHIN 180 DAYS FROM THIS H&P TO BE PERFROMED BY THE SURGERY CENTER'S ANESTHESIA STAFF FOR PRE-SURGICAL CLEARANCE.