McLaren Ambulatory Care Center

PRE-OPERATIVE CLEARANCE CONSULTATION*

***requires completion of all highlighted areas**

Request made by _____ ☐ M.D. ☐ D.O. on _____ (Date)

Reason: _____

_____

_____

_____

_____

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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