

McLaren Print System Order

Order No: 5889
Order Date: 2014-09-19
User: lynn thomas
Phone: 810-487-3500

Ship Location: Flushing Community Medical Center
2487 N Elms Rd
Flushing, MI 48433

Forms

Quantity: 100
Paragon Dept No: 63600
Dept Name: Flushing
Company Number: 810

Order Total Price: 22.60

Form Number: MM-17283
Form Description: Pre-Operative Clearance Consultation
Revision Date: 4/2008
Print: 2 sided full color
Paper: 28# Color Copy Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None

McLaren Anesthesiology Care Center
PRE-OPERATIVE CLEARANCE CONSULTATION

*requires completion of all highlighted areas

Received made by _____ M.D. or _____ Date _____
Patient _____

Allergies _____
Current Medications _____

Past Medical History (check if present) or NONE

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Type I	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> GERD	<input type="checkbox"/> Type II	<input type="checkbox"/> Delirium
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Other _____
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hypothyroidism	
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> EIA	<input type="checkbox"/> Hyperthyroidism	
<input type="checkbox"/> Murmur	<input type="checkbox"/> Transient Ischemic Attack	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Pacemaker/ICD	<input type="checkbox"/> Seizures	<input type="checkbox"/> Chronic Kidney Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Bleeding Disorders	

Past Surgical History _____

Social History

<input type="checkbox"/> Occupation _____	<input type="checkbox"/> Drugs _____
<input type="checkbox"/> Smoking _____	<input type="checkbox"/> Abuse (Psychosocial) _____
<input type="checkbox"/> Alcohol _____	

Family History

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	

Review of Systems (check if present) or NONE

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Altered Bowel Habits
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Constipation	<input type="checkbox"/> Altered Bowel Sounds
<input type="checkbox"/> Cough	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dyspnea/Cyanosis
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Anorexia/Weight Loss
<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Fatigue/Weakness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Weakness in Extremities

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