Name:

Orthopaedic Institute MR#:

Pretesting Fax (212) 260-5260 Date: _____

Pre-Operative Medical Clearance

HISTORY OF PRESENT ILLNESS: Age_____Sex _____ LMP _____

ALLERGIES & DRUG SENSITIVITIES: _____

CURRENT MEDICATIONS: _____

PAST SURGICAL HISTORY: _____

PAST MEDICAL HISTORY	YES/NO	DATE IF ONSET/DESCRIPTION
STEROID COVERAGE:	Y N	
ANESTHESIA PROBLEMS	Y N	
CARDIAC HISTORY	Y N	
MI, Angina, CHF		
Valvular Disease,		
Other Conditions		
PULMONARY HISTORY	Y N	
Asthma, Pneumonia,		
COPD, Other		
CI/HEPATIC HISTORY	Y N	
PUD, Hepatitis,		
Cirrhosis, Other		
KIDNEY DISEASE	Y N	
Renal Insufficiency		
THYROID DISEASE	Y N	
CIRCULATORY DISEASE	Y N	
HTN, Thromboemboli,		
CVA, PVD, Other		
DIABETES MELLITUS	Y N	
OTHER CONDITIONS	Y N	
Urinary Problems,		
Other		

SOCIAL HISTORY YES/NO QUANTIFY OCCUPATION: _____

Smoking Y N _____

Ethanol Y N _____

Drugs Y N _____

SIGNIFICANT FAMILY HISTORY: _____

_____

PHYSICAL EXAMINATION: B.P._____Pulse _____Resp._____

HEENT _____

HEART_____

LUNGS_____

ABDOMEN _____

EXTREMITIES _____

NEUROLOGIC _____

DIAGNOSTIC STUDIES REVIEWED (Within past 2 weeks)	YES/NO	ABNORMAL FINDINGS
ECG - Pts. ≥ 40 years or younger pts. with cardiac/pulmonary disorder	Y N	_____
CXR - Pts. ≥ 60 years or younger pts. with cardiac/pulmonary disease	Y N	_____
LABS - CBS, SMA 6 or SMA 12 in pts. with significant medical history	Y N	_____

PATIENT WITH OWN INTERNIST? If Yes give name _____

Office Telephone Number _____Was he contacted? _____

DIAGNOSES/ADDITIONAL COMMENTS: _____

_____

_____

_____

_____

PATIENT IS CLEARED FOR ANESTHESIA & SURGERY

PHYSICIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____

OFFICE PHONE NUMBER: 212-400-6633

PLEASE FAX #212-260-5260

TESTING REQUIRED CBC,PT,PTT,INR, EKG MEDICAL CLEARANCE.