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Medical Clearance Prior to Surgery

Needs to be performed within 30 days of surgery

Patient Name:

Date of Surgery:

Location of Surgery: Lenox Hill Hospital

Procedure(s):

Tests Required:

Physical

CBC & Electrolytes

EKG

Other:

Stress Test

Cardiac Clearance

Hematology Clearance

Please fax results to: (212) 421-0176

Additional Information:

Please be sure to include all three (3) of the hospital forms attached.

Please include interpretation & initial EKG.

THANK YOU!

**PRESURGICAL –
 HISTORY & PHYSICAL EXAM FORM**

Date of Surgery: _____ Patient Name: _____ DOB: _____

Planned Procedure: _____

History of Present Illness: _____

<u>Past Medical History</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>

Other/Explanation for Positive History: _____

Past Surgical History: _____

Advanced Directive: Yes No _____ Heath Care Proxy: Yes No _____

**LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING:
 OVER THE COUNTER AND HERBAL MEDICATIONS.**

Medication Name	Dose (mg, mcg)	Route (PO, GT, SC, IV)	Frequency

*If more space is required continue on progress note

<u>Review of Symptoms</u>	<u>Neg</u>	<u>Positive</u>	<u>(Check if Positive)</u>	
Constitutional	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/>	Allergies _____ _____ _____ Hx of Anesthesia Reaction: <input type="checkbox"/> Yes <input type="checkbox"/> No Family Hx _____ _____ _____ <u>Social Hx</u> Tobacco _____ Alcohol _____ Drugs _____ Other _____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Angina <input type="checkbox"/> DOE <input type="checkbox"/> Othopnea <input type="checkbox"/> Edema <input type="checkbox"/> Palpitations <input type="checkbox"/> Syncope	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Cough <input type="checkbox"/> Dyspnea <input type="checkbox"/> Pleuritic chest pain <input type="checkbox"/> Other _____	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Stomatitis <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Dysphagia	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Dysuria <input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Hernaturia <input type="checkbox"/> Impotence	
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	Parathesia <input type="checkbox"/> Dysesthesia <input type="checkbox"/> Headache <input type="checkbox"/> Seizure	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Rash <input type="checkbox"/> Ulcers <input type="checkbox"/> Other _____	
Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising <input type="checkbox"/> Epistaxis <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Hematochezia <input type="checkbox"/> Melena	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	Polyuria <input type="checkbox"/> Polydipsia <input type="checkbox"/> Heat/Cold Intolerance	
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Sexual Dysfunction	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain <input type="checkbox"/> Back Pain	
Eyes/Ears	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Hearing <input type="checkbox"/> Decreased Vision	
<input type="checkbox"/> Other			_____	

**PRESURGICAL –
 HISTORY & PHYSICAL EXAM FORM**

Patient Name: _____ DOB: _____ MR # _____ Acct # _____

OB/GYN History (Not Applicable): _____

Age of menarche _____ Date of LMP _____ Age of Menopause _____ Gravida _____ Para _____

Miscarriage(s) _____ Abortion(s) _____ Age at First Pregnancy _____ Age at Last Pregnancy _____

Use of Oral Contraceptives: Yes No Age began oral contraceptives _____ Duration _____

Mammogram Yes No _____ PAP Smear Yes No _____

PHYSICAL EXAMINATION:

Height:	Weight:	BP:	P:	T:	R:	Pain (0-10)	BMI:
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	<u>NL</u>	<u>ABNL</u>	<u>Explanation</u>
General	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest/Lung	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ext	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deferred	<input type="checkbox"/>		
Rectal/Genital/Pelvic			_____
Deferred	<input type="checkbox"/>		
Other (Specify)			_____

Significant Labs/X-rays/Exam Diagram

<u>Labs</u>	<u>NL</u>	<u>ABNL</u>
CBC	<input type="checkbox"/>	<input type="checkbox"/>
CHEM	<input type="checkbox"/>	<input type="checkbox"/>
PT/PTT	<input type="checkbox"/>	<input type="checkbox"/>
UA	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
CXR	<input type="checkbox"/>	<input type="checkbox"/>
EKG	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
(i.e. Stress test, Labs, Endoscopy, Etc.)		
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS _____

No medical contraindications to proposed surgery Yes No _____

Examining Provider _____ LIC# _____ Phone _____

MD Stamp

MD Signature _____ Date _____

SURGEON ASSESSMENT / PLANNED PROCEDURE:

Surgeon Signature _____ Date _____

- I certify that I have re-evaluated this patient and there has been no significant change in his/her clinical condition since the above examination.
- I certify that I have re-evaluated this patient and there is a change in his/her clinical condition. See Progress Note.

Attending Physician Signature: _____ Date _____

Mark any symptoms or illnesses which have occurred in the past five years, any which have significant impact on health (such as chronic disease or disability), or any which may affect this hospitalization/surgery.

General Normal

- Fever
- Weight loss or gain
- Fatigue
- Depression
- Nervousness
- Trouble Sleeping

Head Normal

- Headaches
- Head Injury

Eyes Normal

- Poor vision
- Wear glasses or contacts
- Pain
- Double vision
- Glaucoma
- Cataracts

Ears Normal

- Poor hearing
- Wear hearing aid
- Pain
- Drainage
- Noises or tinnitus
- Balance trouble or vertigo

Nose and Throat Normal

- Frequent sore throat
- Hoarseness
- Nasal stuffiness
- Nasal allergies
- Nose bleeds
- Sinus trouble
- Snoring

Mouth Normal

- Dental problems
- Dry mouth or throat
- Trouble chewing
- Jaw pain
- Loose teeth or dentures

Neck Normal

- Swollen Glands
- Goiter
- Neck pain
- Trouble moving neck
- Trouble swallowing

Endocrine Normal

- Thyroid trouble
- Diabetes
- Heat or cold intolerance
- Excessive sweating
- Excessive thirst or hunger
- Excessive urination

Heart Normal

- High blood pressure
- Heart trouble
- Heart attack
- Rheumatic fever
- Heart murmur
- Chest pain or angina
- Palpitations

Lungs Normal

- Trouble breathing
- Cough
- Spitting blood
- Wheezing
- Asthma
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis

Digestive Normal

- Trouble swallowing
- Heartburn or ulcer
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Rectal Bleeding
- Hemorrhoids

Liver Normal

- Jaundice
- Hepatitis
- Gall stones

Urinary Normal

- Difficulty urinating
- Bloody urine
- Kidney stones
- Kidney failure
- Hemodialysis _____/week*

Back Normal

- Back ache or stiffness
- Back injury

Arms and Legs Normal

- Joint pain or injury
- Weakness
- Paralysis
- Tremors
- Numbness or tingling
- Swelling
- Arthritis
- Gout
- Cramps

Neurologic Normal

- Stroke
- Paralysis
- Seizure disorder
- Memory loss
- Fainting
- Tremors

Bleeding Normal

- Easy bruising
- Prolonged bleeding from cuts
- Frequent nose bleeds
- Bleeding from teeth and gums
- Blood in urine or stool
- Heavy menstrual flow
- Anemia
- Blood transfusion

Reproductive Normal

- Sexually transmitted disease

Gyneologic Not Applicable

- Pregnant
- Last menstrual period (Date _____)

Habits Normal

- Tobacco use _____packs/day
- Alcohol use _____oz/day
- Coffee or tea use
- Aspirin use (Note amounts if used regularly.)

Other Normal

- Intravenous drug use
- Substance abuse

*If patient on hemodialysis, indicate arrangements made for routine or urgent dialysis if necessary.

Comments: _____
