Surgical Clearance Form

Patient

Name: ______________________ DOB: ______________________

Phone: ______________________ Email: ______________________

Address: ______________________

Pre-Op Date: ______________________ Surgery Date: ______________________

Diagnosis: ______________________

Surgery Rec: ______________________

Anesthesia: ______________________ Dosage: ______________________

Patient History

Medical History: ______________________

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Surgery 1: ______________________ Date: ______________________

Surgery 2: ______________________ Date: ______________________

Surgery 3: ______________________ Date: ______________________

Medication 1: ______________________ Dosage: ______________________

Medication 2: ______________________ Dosage: ______________________

Medication 3: ______________________ Dosage: ______________________

Allergies: ______________________

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Other Medical Conditions: ______________________

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Examination

Height: ____________ Weight: ____________ BMI: ____________

Temp: ________ Pulse: ________ BP: ________ RR: ________

HEENT: ______________________ Neck: ______________________

Heart: ______________________ Lungs: ______________________

Abdomen: ______________________ Extremities: ______________________

Labs: ______________________ X-Rays: ______________________

EKG: ______________________ U/A: ______________________

Results

- ☐ The patient is cleared for surgery
- ☐ The patient is NOT cleared for surgery
- ☐ Further tests required

______________________ ______________________

Signature Date

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