

**Mid-Atlantic Surgery Pavilion
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Phone: 410-273-9096
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PHYSICIAN'S PRE-OP EVALUATION

PATIENT'S NAME: _____ **SURGERY DATE:** _____

DIAGNOSIS: _____ **DOB:** _____

SURGICAL PROCEDURE: _____

CURRENT MEDICATIONS:

_____ DOSE _____
_____ DOSE _____
_____ DOSE _____
_____ DOSE _____

SIGNIFICANT MEDICAL HISTORY: _____

ALLERGIC REACTION TO: (state type) _____

Latex Allergy: ___ YES ___ NO

B/P: ___ / ___ **PULSE:** _____ **RESP:** _____ **WEIGHT:** _____ **HEIGHT:** _____
BLOOD SUGAR _____ **LAST A1C** _____

LUNGS: _____

CARDIO-VASCULAR: _____

ABDOMEN: _____

EXTREMITIES: _____

NEURO/PSYCH: _____

MEDICAL DIAGNOSIS: _____

CLEARED FOR SURGERY: _____ **YES** _____ **NO**

IF DIABETIC, RECOMMEND PLAN FOR SURGERY: _____

PHYSICIAN'S NAME & ADDRESS: (Please Print or Use Stamp)

PHYSICIAN SIGNATURE: _____ **DATE:** _____