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SURGICAL CLEARANCE

Patient's Name:_____

Surgeon: _____ DOS:_____

Procedure: _____

Present History:_____

Past History: _____

Medication: _____

_____

Allergies: _____

Family History: _____

Physical Assessment: _____

Temp: _____ BP: _____ Pulse: _____ Resp: _____ Weight: _____

ENT: _____

Lungs: _____

Cardiovascular: _____

GI/GU: _____

Neurological: _____

Patient is medically cleared for surgical procedure? Yes (____) No (____)

Physician's signature: _____ Date: _____