Mid-Atlantic Surgery Pavilion
1111 Beards Hill Road, Suite 700
Aberdeen, Maryland 21001
Phone: 410-273-9096
Fax: 410-273-9146

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:**________________