PLEASE REVIEW THE FOLLOWING GUIDELINES WHICH WERE APPROVED BY THE MEDICAL BOARD BEFORE COMPLETING THE FORM

PRE SURGICAL TESTING REQUIREMENTS

HISTORY AND PHYSICAL

All Patients — Within 30 days of surgery

EKG

Any patient with Diabetes, Hypertension, Cardiac, Vascular, Pulmonary, Renal, or Hepatic Disease

All patients >50 years old — Within 6 months of surgery

CHEST X-RAY

Not required

LABORATORY WORK

Within 30 days of surgery

	General Anesthesia	*MAC*	*Anterior Chamber Surgery- MAC only*
Healthy Patient	none	none	none
Diabetes Hypertension Cardiac/Pulmonary Renal	BMP	BMP	none
Liver disease	CBC, BMP PT/PTT, LFT	CBC, BMP PT/PTT	none
Coumadin therapy	INR	INR	none

For history of anemia or for surgeries where blood loss is expected to be >200cc, please include CBC
For patients on kidney dialysis, K+ should be obtained day of surgery
All diabetic patients glucose levels (i.e. finger stick) to be checked day of surgery
Urine pregnancy day of admission for all women of menstruating age
For patients with AICDs, please see NYEE's policy concerning defibrillators

Patients with more complex medical conditions may require further workup (i.e stress tests, echocardiogram, cardio/pulmonary consult, etc). Please consult anesthesia department or patient's PMD.

CBC = complete blood count, BMP = basic metabolic profile, LFT = liver ftinction test, K+ = potassium
PT/PTT/INR = prothrombin time/partial prothrombin time/international normalized ratio
AICD = internal cardiac defibrillator

310 East 14th Street
New York, NY 10003-4297

ADULT PRE-OPERATIVE MEDICAL EVALUATION

Tel: (212) 979-4306 Fax: (866) 333-0174

Web Form

Patient Name

Surgical Procedure/ Chief Complaint/ Details Present Illness

Surgery Date | Anesthesia Type

Surgeon

Patient Name:

Date of Birth:

Allergy/ Medication Sensitivity:

HISTORY

CONDITION	HISTORY? NO	HISTORY? YES ▶	STABLE? YES	STABLE? NO	INDICATE CONDITION NUMBER (#) - Provide details and general review of systems
(1) Coronary Artery Disease					
(2) Hypertension					
(3) Congestive Heart Failure					
(4) Cardiac Arrhythmia					
(5) Valvular Heart Disease					
(6) Pulmonary Disease					
(7) Diabetes Mellitus					
(8) Bleeding Diathesis					
(9) Renal Disease					
(10) Hepatic Disease					
(11) Other Medical Condition(s)					

Surgical History

Relevant Family/ Social History

Last Menses (If Applicable)	Tobacco Use	ETOH Use	Drug Use

MEDICATIONS & DOSES

PHYSICAL

B.P.		NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
	HEART			
PULSE	LUNGS			

OTHER PERTINENT FINDINGS:

DATA

LABORATORY, EKG, and X-Ray Evaluations ▶ See reverse side of this form for minimum requirements. Supply other pertinent results and information as deemed necessary. Send reports and mounted interpreted EKG's with this form. Please comment here on abnormal results.

CLEARANCE

Do you wish to make any peri-operative management recommendations? ☐ No ☐ Yes

STATEMENT OF CLEARANCE: "There are no medical contraindications for the proposed procedure."

Examiner's Name (Printed)	License #	Date	Time

Examiner's Address	Telephone #

Examiner's Signature	Date	Time

***SURGEONS REVIEW**

☐ **I have reviewed the above H&P. I certify that I have re-evaluated and re-examined this patient immediately prior to the procedure and there has been no significant change in his/her clinical condition since the above examination.**

☐ **I certify that I have re-evaluated and re-examined this patient immediately prior to the procedure and there is a change in his/her clinical condition. See Progress Note.**

Surgeons Signature	Print Name	Date	Time

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