Clear Form

Medical Clearance

Name: _____ D.O.B.: _____ M / F Age: _____

Referred by: _____ Surgery Date:_____Allergy: _____

Present Illness: _____

_____

R.O.S.: _____

Past History (including history of bleeding tendency, allergy, and significant illness): _____

_____

_____

Family History (including history of bleeding tendency, allergy, and significant illness): _____

_____

Significant Laboratory Data, if Pertinent: _____

_____

PHYSICAL EXAMINATION:

General Appearance: _____ HT: _____cm.

B.P.:_____ R:_____ P: _____ T:_____ WT:_____kg.

Skin: _____ Adenopathy: _____ BMI _____%

Nutritional Status: _____ Neuro: _____

H.E.E.N.T: _____

_____

Heart: _____ Lungs: _____

Abdomen: _____Genitalia: _____

Extremities: _____ Musculoskeletal: _____

Description of Clinical Problem/s: _____

_____

Cleared for Surgery: ☐

Not Cleared: ☐ Pending Further Evaluation of :

_____

_____

Name:

D.O.B.:

Age:

_____ MD/DO/ARNP/PA-C

_____ Date/Time

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