DATE: ____________________________________________

PATIENT’S NAME: __________________________________

TENTATIVE SURGERY DATE: ____________________

SURGEON: __________________________________________

Dear Dr. ____________________________

The above named patient is scheduled for surgery. This will be performed with careful monitoring which includes anesthesia and Registered Nurses.

In order to provide this patient with the best possible care during their surgical procedure, please complete the enclosed patient history form. Diagnostic testing is not required unless you feel it medically necessary. If you do perform any blood work or EKG, please provide the results to us.

Please fax this form to our office at least one week prior to the surgery date.

FAX TO: 985-641-2790

If you have any questions, do not hesitate to call us at 504-737-3456. Thank you for your prompt attention to this matter.
PATIENT HISTORY

PATIENT NAME: _____________________________ AGE: _______
ALLERGIES: _______________________________________________________
EXAMINATION DATE: ___________ SURGEON: __________________________
B/P: ___________ PULSE: _______ RESP.: _______ TEMP.: ___________
PAST MEDICAL HISTORY: _____________________________________________
CURRENT MEDICATIONS: ____________________________________________
GENERAL APPEARANCE: _____________________________________________
HEART: ___________________________________________________________
LUNGS: ___________________________________________________________
EXTREMETIES: ______________________________________________________
LAB DATE: _________________________________________________________
HGB: ___________ HCT: ___________ PLT: ___________
GLUCOSE: ___________ NA: ___________ K: ___________
BUN: ___________ CR: ___________
SIGNIFICANT OTHERS: ______________________________________________
EKG: _____________________________________________________________
(Please send an interpreted copy if done)
[ ] CLEARED FOR SURGERY VALID FOR _______ WEEKS.
[ ] IS NOT CLEARED DUE TO: _______________________________________
[ ] REFERRED TO ______________________ FOR LAB [ ] EKG [ ]

CLEARED BY: ________________________________