CONNECTICUT EAR·NOSE·THROAT
MEDICAL AND SURGICAL SPECIALISTS

Medical History Review

PRE-PROCEDURE MEDICAL EVALUATION

15 Corporate Dr.
Trumbull, CT 06611
203-452-7081 Fax: 452-7089

TO DR: ______________________________

PATIENT: ______________________________

REQUESTED BY: TOM K. COFFEY, M.D. ADAM W. PEARL, M.D.

SURGICAL PROCEDURE/DATE:

REQUIRED FOR SURGERY:

____**H & P**

____**BLOODWORK**

____**EKG**

____**CHEST X-RAY**

PATIENT HISTORY/REVIEW OF SYSTEMS

PRIOR SURGERY/ANESTHESIA ______________________________

ALLERGIES

MEDICATIONS/DOSAGES

PHYSICAL EXAM

VITAL SIGNS: BP ____________ PULSE ____________ RESP ____________ TEMP ____________

MENTAL STATUS _____ ALERT AND ORIENTED
_____ OTHER (SPECIFY)

HEART	LUNG

OTHER PERTINENT FINDINGS

IS PATIENT IN OPTIMAL MEDICAL CONDITION FOR PLANNED PROCEDURE? _____YES _____NO (EXPLAIN)

RECOMMENDATIONS FOR CONTINUING THERAPY DURING PREOPERATIVE PERIOD

DATE OF EXAM

PRINTED NAME -- EVALUATING PHYSICIAN

SIGNATURE OF EVALUATING PHYSICIAN

PLEASE FAX COMPLETED FORM TO 203-452-7089

revised Aug. 10, 2010