CONNECTICUT
EAR•NOSE•THROAT
MEDICAL AND SURGICAL SPECIALISTS, P.C.

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# PRE-PROCEDURE MEDICAL EVALUATION

TO DR: ______________________________

PATIENT: ______________________________

REQUESTED BY: ADAM W. PEARL M.D. Derek Kong M.D.

SURGICAL PROCEDURE\DATE:

**REQUIRED FOR SURGERY:**

H&P___ BLOODWORK___

EKG ___ CHEST X-RAY___

PATIENT HISTORY/REVIEW OF SYMPTOMS

______________________________

______________________________

______________________________

PRIOR

SURGERY/ANESTHESIA______________________________

ALLERGIES______________________________

MEDICATIONS/DOSAGES______________________________

______________________________

PHYSICAL EXAM HT: ________ WT: ________

VITAL SIGNS: BP: ________ PULSE: ________ RESP: ________ TEMP: ________

MENTAL STATUS ________ ALERT AND ORIENTED ________ OTHER (SPECIFY)

HEART________________ LUNGS________________

OTHER PERTINENT

FINDINGS______________________________

______________________________

IS PATIENT IN OPTIMAL MEDICAL CONDITION FOR PLANNED PROCEDURE? YES ______

NO_____(EXPLAIN)______________________________

RECOMMENDATIONS FOR CONTINUTING THERAPY DURING PREOPERATIVE

PERIOD______________________________

______________________________

DATE OF EXAM

PRINT NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

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