RETINAL AMBULATORY SURGERY CENTER OF NEW YORK
PRE-OPERATIVE MEDICAL EVALUATION

Patients Name:
D.O.B.
Surgical Procedure:

Surgery Date:
Surgeon:

DATE OF CLEARANCE:

Affix patient's name sticker here

HISTORY

MEDICAL CONDITION	HISTORY? YES	HISTORY? NO	STABLE? YES	STABLE? NO	INDICATE CONDITION NUMBER (#) AND COMMENT BELOW REGARDING MEDICAL CONDITION TYPE AND DURATION
1. Diabetes Mellitus					If Myocardial Infarction or CVA indicate type and year (s):
2. Hypertension					
3. Coronary Artery Disease					
4. Congestive Heart Failure					
5. Cardiac Arrhythmia					
6. Valvular Heart Disease					
7. Pulmonary disease (Asthma,COPD)					
8. Bleeding Disorder					
9. Renal Disease (Dialysis?)					
10. Hepatitis A, B, C					
11. Neurological Disorder (Seizures?)					
12. Other					

Problems with Anesthesia?

Medication and other allergies/Sensitivity and reaction:

Last menses (If applicable)	Tobacco use	ETOH use	Drug use

MEDICATION/ DOSE/FREQUENCY:

PHYSICAL

PULSE		NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
	HEART			
	LUNGS			

OTHER PERTINENT FINDINGS:

CLEARANCE

STATEMENT OF MEDICAL CLEARANCE: **"Patient is cleared for surgery in an Ambulatory Setting".**

EXAMINER'S SIGNATURE	Examiner's Name (Printed)	**License #** **Date of clearance:**

Examiner's address
Telephone #

REVIEWED BY: (Surgeon's signature)	Date Reviewed:

UPDATE:

THERE WERE NO NEW MEDICAL DEVELOPMENTS NOTED ON THE DAY OF THE PROCEDURE.	Patient evaluated by Anesthesiologist: (signature)	Date: