PATIENT'S NAME: _____ DOB: _____

PLANNED PROCEDURE: _____ PROCEDURE DATE: _____

_____

HISTORY

CHIEF COMPLAINT: _____

DIAGNOSIS: _____

ALLERGIES: ☐ NONE ☐ LATEX ☐ OTHER _____

_____

_____

MEDICAL HISTORY: _____

_____

SURGICAL HISTORY: _____

CURRENT MEDICATIONS (include dosage): _____

_____

_____

SOCIAL HISTORY:

SMOKING ☐ NO ☐ YES ☐ CURRENT_____ ☐ HISTORY_____

ALCOHOL ☐ NO ☐ YES QUANTITY:_____

RECREATIONAL DRUGS ☐ NO ☐ YES ☐ CURRENT_____ ☐ HISTORY_____

PHYSICAL EXAMINATION

GENERAL _____

MENTAL STATUS ☐ WNL ☐ VARIANCE _____

NEUROLOGICAL ☐ WNL ☐ VARIANCE _____

HEAD & NECK ☐ WNL ☐ VARIANCE _____

ENT ☐ WNL ☐ VARIANCE _____

CARDIAC ☐ WNL ☐ VARIANCE _____

PULMONARY ☐ WNL ☐ VARIANCE _____

VASCULAR ☐ WNL ☐ VARIANCE _____

GI ☐ WNL ☐ VARIANCE _____

URO/GENITAL ☐ WNL ☐ VARIANCE _____

OTHER _____

MEDICALLY CLEARED ☐ YES ☐ NO ☐ N/A

PHYSICIAN SIGNATURE: _____ PRINT NAME: _____

DATE:_____ TIME:_____

Physician performing procedure must check and document immediately prior to procedure.

☐ No changes in patient status from above H&P

☐ Note changes _____

_____

PHYSICIAN SIGNATURE: _____ PRINT NAME: _____

DATE:_____ TIME:_____

Kimball Medical Center

SAME DAY SURGERY
MEDICAL CLEARANCE FORM