Virginia Head and Neck Surgeons

19455 Deerfield Ave, Suite 301
Leesburg, VA 20176
Phone 703-858-4439
Fax 703-858-4489

Pre-op History & Physical Clearance form

Patients Name: ____**DOB** _____________

Surgical Date ____/____/____

Surgical Procedure ____

BP _____/_____ **WT** ______ **HT** _____ **P**______ **RR**______

Medical History

Medical/ Surgical

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Physical Exam

	NL	ABN		NL	ABN
HEENT	□	□	Abdomen	□	□
Heart	□	□	Extremities	□	□
Lungs	□	□	Neuro Status	□	□

Allergies

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Current Medications____

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Labs/Tests

EKG (IF 50 or older)	□	CXR	□
CBC w/ DIFF	□	Chem. 7	□
Lipid Panel	□	Kidney Function	□
TSH	□	U/A	□
Other	□	________________________	

Please Fax a copy of Clearance, Lab work, and EKG to 703-858-4489 TWO Days before Surgery.

Physician Signature ______________________________ Date ____/____/_____