

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

Physical Exam

	NL	ABN		NL	ABN
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Neuro Status	<input type="checkbox"/>	<input type="checkbox"/>

Allergies

Current

Medications _____

Labs/Tests

EKG (IF 50 or older)	<input checked="" type="checkbox"/>	CXR	<input type="checkbox"/>
CBC w/ DIFF	<input checked="" type="checkbox"/>	Chem. 7	<input type="checkbox"/>
Lipid Panel	<input type="checkbox"/>	Kidney Function	<input type="checkbox"/>
TSH	<input type="checkbox"/>	U/A	<input type="checkbox"/>
Other	<input type="checkbox"/>	_____	

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

Physician Signature _____ Date ____/____/____