

**VIRGINIA HEAD AND NECK SURGEONS**

19455 Deerfield Ave, Suite 301 | Lansdowne, VA 20176  
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Phone: 703-858-4439 | Fax: 703-858-4489



**PRE-OPERATIVE HISTORY & PHYSICAL CLEARANCE FORM**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Surgical Date:** \_\_\_\_\_

**Procedure:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HT:** \_\_\_\_\_ **WT:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **P:** \_\_\_\_\_ **RR:** \_\_\_\_\_

**Medical/Surgical History:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** \_\_\_\_\_

\_\_\_\_\_

Physical Exam:	Normal	Abnormal
HEENT	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Neuro Status	<input type="checkbox"/>	<input type="checkbox"/>

**Labs/Tests**

CBC w/ Diff     EKG ≥50     CMP     CXR     TSH     UA

Other: \_\_\_\_\_

*Please fax a copy of the history & physical, along with any labs/tests completed, to 703-858-4489 AND 571-206-3938 at least three days before surgery.*

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_