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PREOPERATIVE EVALUATION

PT NAME :_____ **DOB** :_____

Proposed Procedure :_____

Date of Surgery :_____ **Anesthesia Type** :_____

The above patient has been scheduled for outpatient ophthalmic surgery. Please provide the following information:

Past Medical history: _____

_____

Medication : _____ **Allergies** :_____

_____ _____

Has the patient exhibited any bleeding tendencies : Yes_____ No_____

If yes, please explain: _____

_____

Are there any reasons that you feel the patient should not have outpatient surgery : Yes _____ No_____

If yes, please explain:

_____

_____

Findings or general medical examination: _____

_____

_____

Appointment Date :_____ **Dr's Signature**: _____

Please return by : _____ **ASAP** _____ **Date**:_____

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