New York Eye and Ear Infirmary of Mount Sinai

310 East 14th Street
New York, NY 10003-4297
Tel: (212) 979-4306 Fax: (866) 333-0174

ADULT PRE-OPERATIVE MEDICAL EVALUATION

NUR PREOPMEDEV

Patient Name | Date of Birth

Surgical Procedure/ Chief Complaint/ Details Present Illness

Surgery Date | Anesthesia Type

Surgeon

Allergy/ Medication Sensitivity:

HISTORY

CONDITION	HISTORY? NO	HISTORY? YES ▶	STABLE? YES	STABLE? NO	INDICATE CONDITION NUMBER (#) - Provide details and general review of systems
(1) Coronary Artery Disease					
(2) Hypertension					
(3) Congestive Heart Failure					
(4) Cardiac Arrhythmia					
(5) Valvular Heart Disease					
(6) Pulmonary Disease					
(7) Diabetes Mellitus					
(8) Bleeding Diathesis					
(9) Renal Disease					
(10) Hepatic Disease					
(11) Other Medical Condition(s)					

Surgical History

Relevant Family/ Social History

Last Menses (If Applicable) | Tobacco Use | ETOH Use | Drug Use

MEDICATIONS & DOSES

PHYSICAL

B.P.		NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
	HEART			
PULSE	LUNGS			

OTHER PERTINENT FINDINGS:

DATA

LABORATORY, EKG, and X-Ray Evaluation ▶ See NYEE website (Admitting Forms - item 1. b.) for minimum requirements. Supply other pertinent results deemed necessary. Send reports and mounted interpreted EKG's with this form. Please comment here on abnormal results.

CLEARANCE

Do you wish to make any peri-operative management recommendations? ☐ No ☐ Yes

STATEMENT OF CLEARANCE: "There are no medical contraindications for the proposed procedure."

Examiner's Name (Printed) | License # | Date | Time

Examiner's Address | Telephone #

Examiner's Signature | Date | Time

*SURGEON'S REVIEW

I have reviewed the above documented history and physical examination and have reevaluated and reexamined the patient. Except for any changes or findings listed below, I certify that the patient's history, physical findings and condition are materially unchanged:

_____

Surgeon Signature | Print Name | Date | Time