Center for Gynecologic Oncology & Women's Health
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Patrick Anderson, M.D.

PRE-OPERATIVE MEDICAL EVALUATION

PATIENT NAME:		**DATE OF BIRTH:**
PLANNED SURGERY DATE:		**SURGEON:** ***Dr. Patrick Anderson***
NAME OF PHYSICIAN CONDUCTING EVALUTION:		
DATE OF OFFICE VISIT:		
PAST MEDICAL HISTORY		
ALLERGIES:		
MEDICATIONS:		
PHYSICAL EXAM: BP:	HR:	HT: WT:
HEENT	□ NORMAL	□ ABNORMAL
NECK	□ NORMAL	□ ABNORMAL
COR	□ NORMAL	□ ABNORMAL
PULM	□ NORMAL	□ ABNORMAL
GI	□ NORMAL	□ ABNORMAL
EXT	□ NORMAL	□ ABNORMAL
M/S	□ NORMAL	□ ABNORMAL
SKIN	□ NORMAL	□ ABNORMAL
DATE:	LABS:	
	EKG:	
	CHEST X-RAY:	
	OTHER:	
□ THE ABOVE PATIENT IS MEDICALLY CLEARED FOR SURGERY □ THE ABOVE PATIENT IS ***NOT*** MEDICALLY CLEARED FOR SURGERY		
RECOMMENDATIONS:		
PRINT NAME MD/ND/PA:		LICENSE #
SIGNATURE:		DATE:
OFFICE ADDRESS:		PHONE: