

**PRE-OPERATIVE MEDICAL CONSULTATION FORM**

Please complete and fax to: Ambulatory Surgery @ 631-351-2763 and Dr. \_\_\_\_\_ @ \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Consult Requested of: \_\_\_\_\_ by Dr. \_\_\_\_\_

Surgical Date: \_\_\_\_\_ PST Date: \_\_\_\_\_ Procedure \_\_\_\_\_

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**CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS:**

**PAST HISTORY:**

- Diabetes: \_\_\_\_\_
- Allergies: \_\_\_\_\_
- Hypertension: \_\_\_\_\_
- Current Medications: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_
- Hospitalizations/Surgeries: \_\_\_\_\_
- Pulmonary Disease: \_\_\_\_\_
- GI Disease: \_\_\_\_\_
- Other: \_\_\_\_\_

**PHYSICAL Exam:** *If any physical element is deferred a reason must be documented.*

- BP/P/R: \_\_\_\_\_
- Abdomen: \_\_\_\_\_
- HEENT: \_\_\_\_\_
- Genitalia: \_\_\_\_\_
- Neck: \_\_\_\_\_
- Rectal: \_\_\_\_\_
- Heart: \_\_\_\_\_
- Extremities: \_\_\_\_\_
- Lungs: \_\_\_\_\_
- Neurological: \_\_\_\_\_
- Breast: \_\_\_\_\_
- Mental Status: \_\_\_\_\_

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For Pediatric Patients Only: Are immunization record up-to-date?  YES  NO

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Assessment & Recommendations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician Signature\*

\_\_\_\_\_  
Print

\_\_\_\_\_  
Date

\*Physician's not on staff at Huntington Hospital, please complete:

Name: \_\_\_\_\_ License No.: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_