LEBEAU CLINIC

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Pre-op Evaluation

This patient is scheduled for in office Surgery in the near future. Please fax or email this form with any relevant supporting documentation to LeBeau Clinic. Your assistance is greatly appreciated.

Patient's Name: ______________________________ Date of Birth: __________

Patient's Phone: ______________________________

Pre-op Date: __________ Surgery Date: __________

Proposed Surgery: ______________________________

Anesthesia: Local with oral sedation

Significant past medical history: ______________________________

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List of previous operations: ______________________________

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Current Medications with Dosages:

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Drug Allergies:

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B:P: __________ Pulse: __________ LUNGS: __________

CARD/VASC: __________ NEURO/PSYCH: __________

ABD: __________ EXT: __________ HEENT: __________

Perioperative Recommendations: ______________________________

Is this patient cleared to have surgery? ______________________________

Date: __________ Print Name: ______________________________

Signature: ______________________________

Jacque LeBeau, MD

1020 N Palafox Street • Pensacola, Florida 32501 • 850.308.1738 • Fax 850.308.5420 • www.lebeauclinic.com