



EYECARE 20/20

Date: \_\_\_\_\_

Re: Patient's name: \_\_\_\_\_

Tentative Surgery Date: \_\_\_\_\_

Surgeon: Neil Notaroberto, M.D.

Dear Dr. \_\_\_\_\_

The above named patient is scheduled for surgery. This will be performed with careful monitoring which includes anesthesia and Registered Nurses.

In order to provide this patient with the best possible care during their surgical procedure, please complete the enclosed patient history form. Diagnostic testing is not required unless you feel it is medically necessary. If you do perform any bloodwork or EKG, please provide the results to us.

**Please fax this form to our office prior to the surgery date.  
(985)624-6613**

If you have any questions, do not hesitate to call us at (985)624-5058. Thank you for your prompt attention to this matter.

Sincerely,

Neil Notaroberto, M.D.

# 2 Sanctuary Blvd. Suite 303 Mandeville, LA 70471

**PATIENT HISTORY**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Allergies: \_\_\_\_\_

Examination Date: \_\_\_\_\_ Surgeon: Neil F. Notaroberto, M.D.

B/P \_\_\_\_\_ PULSE \_\_\_\_\_ RESP. \_\_\_\_\_ TEMP. \_\_\_\_\_

PAST MEDICAL HISTORY: \_\_\_\_\_

CURRENT MEDICATION: \_\_\_\_\_

GENERAL APPEARANCE: \_\_\_\_\_

HEART: \_\_\_\_\_

LUNGS: \_\_\_\_\_

EXTREMITIES: \_\_\_\_\_

LAB DATE: \_\_\_\_\_

HGB: \_\_\_\_\_ HCT: \_\_\_\_\_ PLT: \_\_\_\_\_ WBC: \_\_\_\_\_

GLUCOSE: \_\_\_\_\_ NA: \_\_\_\_\_ K: \_\_\_\_\_ BUN: \_\_\_\_\_

CR: \_\_\_\_\_ SIGNIFICANT OTHERS: \_\_\_\_\_

EKG: \_\_\_\_\_

(Please send an interpreted copy if done)

Cleared for surgery. Valid for \_\_\_\_\_ Weeks.

Is not cleared due to: \_\_\_\_\_

Referred to \_\_\_\_\_ for LAB  EKG .

Cleared by: \_\_\_\_\_