

WILLIAM A. GRABER, M.D., F.A.C.S
MATTHEW A. FITZER, M.D.
WEIGHT LOSS SURGERY
TELEPHONE: 315-624-4740 FAX: 315-624-4760

To: _____

Patient: _____

DOB: _____

Mr./Ms. _____

Is scheduled for a videoscopic _____ on
_____/_____/_____ at St. Luke's Hospital to be performed by
Dr. Graber/Dr. Fitzer under general anesthesia.
Estimated length of surgery being _____ hours.

Mr./Ms. is scheduled to see you for a pre-operative medical exam and EKG on
_____/_____/_____. Please send a letter of medical consultation and a copy
of the EKG to our office.

PAST MEDICAL HISTORY:

Previous Surgeries:

List Co-morbidities:

Medications with doses:

Allergies with manifestations:

Family History:

Pertinent psychosocial history:

Please complete page 2 of physical examination.

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General Appearance: _____

Pulse _____ **Blood Pressure** _____ **Temp** _____ **Weight** _____ **Height** _____

HEENT:

NECK:

BREAST:

REPRODUCTIVE (PAP Smear):

CHEST:

CARDIAC:

ABDOMEN:

SKIN:

EXTREMITIES:

NEUROLOGICAL/MENTAL STATUS:

CONCLUSION/IMPRESSIONS:

PHYSICIANS PRE-OP ORDERS/NOTES

PATIENT IS MEDICALLY CLEARED FOR SURGERY YES _____ NO _____

MD SIGNATURE: _____ **DATE:** _____ / _____ / _____