



ZIV M. PELED, MD
—PELED PLASTIC SURGERY—



ZIV M. PELED, MD
—PELED MIGRAINE SURGERY—



ZIV M. PELED, MD
—PELED NERVE SURGERY—

PRE-OP FORM

Pt Name: _____ Exam Date: _____ Procedure Date: _____
Pt Age: _____ Temp: _____ BP: _____ HR: _____ RR: _____

Planned Procedure:

PMH: _____

ROS:	Negative	Positive	If positive, please specify:
• Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
• CNS	<input type="checkbox"/>	<input type="checkbox"/>	_____
• GU	<input type="checkbox"/>	<input type="checkbox"/>	_____

PE:			
• HEENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____

Assessment & Plan:

Recommendations prior to surgery:

Physician signature: _____

Date: _____