CENTER for DENTAL ANESTHESIA

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Patient:_____ Physician:_____

Date of Procedure:_____ Physicians Phone:_____

Date of Birth:_____ Age:_____

History: (-) if negative **(+) if positive**

Allergies:_____ Previous Surgeries: _____

Asthma:_____ Previous Surgical Complication:_____

Pulmonary Disease:_____ Recent Exposure to Varicella:_____

Bleeding Tendency:_____ Seizure Disorder:_____

Diabetes:_____ Tx: _____ Sickle Cell or Variant:_____

Heart Murmur:_____ Other Hematological Abnormalitites: _____

EKG Required for over 50 years old _____ Family History of Bleeding, Muscle Disease or Anesthesia

Heart Disease or Defect: _____ Complications: _____

If yes: Stress test _____ 2-D Echo: _____ Other Conditions: _____

Immunizations up to date? Yes _____ No _____ Recent ASA: _____

Daily Medications? Dose and Schedule:_____

Physical Examination:

Vitals: Ht. _____ Wt. _____ Temp _____ Resp. Rate _____ BP_____ / _____

Mental Status: _____ Throat: _____ Lungs: _____

Eyes: _____ Neck: _____ Abdomen: _____

Ears: _____ Chest: _____ Extremities: _____

Nose: _____ Heart: _____ Neurological: _____

Lab Data:

Hct: _____ Hgb:_____ UA: _____ Glucose: _____ Other: _____

Summary:

Suggestions Prior to Surgery (and for perioperative management):

Patient is Cleared for IV/General Anesthesia: Signature _____,MD

Date:_____

Please return by:_____; Patient's appointment date is:_____