



CENTER for DENTAL ANESTHESIA

5284 Dawes Avenue, Alexandria VA 22311, Tel (703)379-6400, Fax (703)379-6407
E-mail: info@snoozedentistry.org

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 Abnormalities: _____
Heart Disease or Defect: _____ Family History of Bleeding, Muscle Disease or Anesthesia Complications: _____
If yes: Stress test _____ 2-D Echo: _____
Immunizations up to date? Yes _____ No _____ Recent ASA: _____

Physical Examination:

Vitals: Ht. _____ Wt. _____ BMI: _____ Temp. _____ Resp. Rate _____ BP _____ / _____ HR _____
Mental Status: _____ Throat: _____ Lungs: _____
Eyes: _____ Neck: _____ Abdomen: _____
Ears: _____ Chest: _____ Extremities: _____
Nose: _____ Heart: _____ Neurological: _____

Summary:

Suggestions Prior to Surgery (and for perioperative management):

MUST INCLUDE IN ORDER TO PROCEED WITH IV/GENERAL ANESTHESIA

- I. EKG (Required for over 50 years old)
- II. History & Physical (Within 6 months)
- III. Recent Lab Work & Data
- IV. COMPLETE List of Medications and Dosages

Patient is CLEARED for IV/General Anesthesia:

Signature: _____ MD Date: _____