



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: _____

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: _____