PRE-OPERATIVE PHYSICAL EXAMINATION FOR DENTAL CARE UNDER GENERAL ANESTHESIA

A primary care physician must complete all sections and return to Discovery Dental, LLC at least SEVEN (7) days prior to scheduled dental surgery date. This physical will expire 30 days from the date signed. Thank you.

Patient Name:_____ Date of Surgery:_____

Date of Birth:_____

Current Medications

(Please list all medications, including over the counter medications. Attach additional pages if necessary.)

Medication	Dosage	For the Treatment of

Please list all allergies to food, medication or latex. Include patient and/or family history of anesthesia complications:

Please describe any hospitalizations or changes in medical history over the past year:

CURRENT HEALTH STATUS/MEDICAL TREATMENTS/ISSUES

Please specify all conditions that were an issue within the last 12 months

Asthma ___Y ___N

Apnea/Dysphagia ___Y ___N

Anti-Coagulants ___Y ___N

Airway Problems ___Y ___N

Bleeding Disorders ___Y ___N

Cancer ___Y ___N

Diabetes ___ Type 1 ___ Type 2

Heart Disease ___Y ___N

Hepatitis ___Y ___N

Hypertension ___Y ___N

Kidney Disease ___Y ___N

Liver Disease ___Y ___N

Muscular Disease ___Y ___N

TE/COPD/Pneumonia ___Y ___N

Date of last/Infiltrate ___/___/___

Seizure Disorder ___Y ___N

Change in Seizure: __ Frequency __ Pattern __ Medication

__ Other:_____

Date of Last Seizure ___/___/___

Hospitalized after seizure? ___Y ___N

Peg Tube Fed ___Y ___N

Scoliosis/Degree of Curvature _____

Sexually Active ___Y ___N

Weight Gain/Loss ___Y ___N

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, PLEASE PROVIDE A COMPLETE DESCRIPTION FOR EACH CONDITION.

Patient Name:_____ Date:_____/_____/_____

PLEASE PROVIDE A COMPLETE DESCRIPTION FOR EACH ABNORMAL/OMITTED CONDITION

General Appearance	__ Normal	__Abnormal	__Omitted
Mental Status	__ Normal	__Abnormal	__Omitted
Skin/Heent	__ Normal	__Abnormal	__Omitted
Heent	__ Normal	__Abnormal	__Omitted
Lymph Nodes	__ Normal	__Abnormal	__Omitted
Lungs	__ Normal	__Abnormal	__Omitted
Heart	__ Normal	__Abnormal	__Omitted
Abdomen	__ Normal	__Abnormal	__Omitted
Urinary	__ Normal	__Abnormal	__Omitted
Extremities	__ Normal	__Abnormal	__Omitted
Musculo-Skeletal	__ Normal	__Abnormal	__Omitted
Neurology	__ Normal	__Abnormal	__Omitted

Temperature_____ B/P_____ Pulse_____ Resp._____ Height_____ Weight_____

I hereby certify that I have examined the named patient and attest that he/she is stable to undergo dental surgery under general anesthesia. This physical will expire <u>30 DAYS</u> from the date signed.

_____ _____

Physician's Signature Date

_____ _____

Physician's Name (please print) Telephone Number/Fax Number

MD MUST SIGN PHYSICAL