(301) 778-0411
(301) 778-0471
info@sleepysmilesdental.com

Medical Clearance for General Anesthesia Low Risk Surgical Procedure

Patient Name:	Date:
Procedure: **Dental exam and surgery under general anesthesia**	
Date of Surgery:	

To whom it may concern,

This patient is seeking to be treated under General Anesthesia for a low risk surgery. Please complete the enclosed Medical Clearance form and fax or scan the completed H&P and all accompanying documents (blood tests, EKG's, etc as recommended by PCP and any relevant specialists) to:

Sleepy Smiles Dental
Phone: (301) 778-0411
Fax: (301) 778-0471
Email: info@sleepysmilesdental.com

Forms must be filled out COMPLETELY. Forms not completed will be sent back

If you should have any questions or concerns, please feel free to contact us.

Regards,

Sleepy Smiles Dental

Thank you

History and Physical for Low Risk Surgery under General Anesthesia

PLEASE FILL OUT FORM BELOW COMPLETELY. Forms not completed will be sent back.

Patient Name: ______________________ **DOB:** ____________ **Date:** ______

Height MUST be documented in Inches AND Weight MUST be documented in kilograms.

Sex	Race	Age	Height	Weight	Percentile (Pediatrics)	BMI (ADULTS)	BP	Pulse	Resp	Temp
			in.	kg	%		/			

Review of Systems (Check ALL that Apply OR check None)

Cardiovascular: ___ None
___ Congenital Heart dz
___ Hypertension
___ Angina/Chest Pain
___ MI/CAD
___ CHF
___ Arrhythmia/palpitations
___ Pacemaker/AICD
___ Valvular Disease
___ CABG/Cardiac Surgery
___ Coronary Stent
___ Poor Exercise Tolerance
___ PVD
___ Other ____________

Hematologic: ___ None
___ Anemia
___ Sickle Cell Disease
___ Sickle Cell Trait
___ G6PD
___ Bleeding Disorder
___ Cancer
___ Chemotherapy
___ Other ____________

Pulmonary: ___ None
___ Asthma/RAD
___ COPD/Emphysema
___ Smoking History
___ SOB
___ Sleep Apnea/Snoring
___ CPAP
___ Cough
___ Wheezing
___ PND/Orthopnea
___ URI
___ Other ____________

Anesthesia Airway: ___ None
___ Family Hx Anesthesia Issues
___ Previous Anesthesia Issues
___ Other ____________

Pediatrics: ___ None
___ Recent URI/Illness
___ Developmental Delay
___ Prematurity; specify ___weeks
___ Congenital Anomaly
___ Other ____________

Neurological: ___ None
___ TIA or stroke
___ Head Trauma
___ Seizures
___ Cerebrovascular Disease
___ Dementia
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Psychiatric Disorder
___ Neuromuscular Disease
___ Syncope
___ Shunt
___ Other ____________

Psychological: ___ None
___ Autism
___ Asperger's
___ PDD or NOS
___ ADHD or ADD
___ Other ____________

GYN: ___ None
___ Pregnant
___ LMP ____________

Gastrointestinal: ___ None
___ Gastroenteritis
___ Hernia; specify ________
___ Constipation
___ Diarrhea
___ Reflux
___ Hepatitis Type ________
___ Cirrhosis
___ Thyroid Disease
___ Recent Steroid Use
___ Obesity
___ Other ____________

Kidney/Renal: ___ None
___ Kidney Disease
___ Recent UTI
___ Other ____________

Other: ___ None
___ Thyroid Disease
___ Recent Steroid Use
___ Diabetes Type I or II
___ Autoimmune Disorders
___ Eczema
___ Other ____________

Allergies/RXN (Medication/Seasonal/Foods): ______________________________

Current Medications:

Medication: ______________________ Dosage: __________ Frequency: ________

Medication: ______________________ Dosage: __________ Frequency: ________

Medication: ______________________ Dosage: __________ Frequency: ________

Surgical Hx: ______________________________

Most recent Illness: ______________________ Date of Illness: __________

General Appearance: ______________________________

✔ Check ALL that Apply:

HEENT:
☐ No Lymphadenopathy
☐ No Sore Throat/Cough
☐ No Nasal Congestion
☐ EOMI
☐ PERRLA
☐ Abnormal: ________

Neurological:
☐ DTR Intact and Equal B/L
☐ NML Mental Status
☐ Abnormal: ________

Cardiovascular:
☐ RRR
☐ S1S2
☐ Abnormal: ________

Pulmonary:
☐ CTA B/L
☐ Abnormal: ________

Gastrointestinal:
☐ Abd Benign-Normoactive BS
☐ No Hepatosplenomegaly
☐ Abnormal: ________

Musculoskeletal:
☐ NML Muscle Tone
☐ NML Strength
☐ Abnormal: ________

I certify I have completed the patient's history and physical. I cleared this patient for General Anesthesia.

Doctor Signature: ______________________ **Date:** __________

Doctor Name (Printed) : ______________________ **Phone #:** __________

Office Name: ______________________ **Fax#:** __________