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PRE-OPERATIVE PHYSICAL EXAMINATION FOR DENTAL CARE UNDER GENERAL ANESTHESIA

*A Primary Care Physician must complete all sections and return to Special Smiles, Ltd at least **SEVEN (7)** days prior to the scheduled dental surgery date. This physical will expire 60 days from the date signed. Thank You.*

PATIENT NAME: _____ Date of Birth: ____/____/____	DATE OF SURGERY ____/____/____**
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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: YES NO

CURRENT HEALTH STATUS/MEDICAL TREATMENTS/ISSUES

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

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MUSCULAR DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> APNEA /DYSPHAGIA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> TB/COPD/PNEUMONIA	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ANTI-COAGULANTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last /infiltrate	____/____/____
<input type="checkbox"/> AIRWAY PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> SEIZURE DISORDER	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BLEEDING DISORDERS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Change in Seizure <input type="checkbox"/> Frequency <input type="checkbox"/> Pattern <input type="checkbox"/> Medication	
<input type="checkbox"/> CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> DIABETES <input type="checkbox"/> TYPE 1	<input type="checkbox"/> TYPE 2	Date of Last Seizure	____/____/____
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hospitalized after seizure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PEG TUBE FED	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> SCOLIOSIS/ DEGREE OF CURVATURE _____	
<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> SEXUALLY ACTIVE	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> WEIGHT GAIN/LOSS	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

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 60 DAYS FROM THE DATE SIGNED.

Physicians Signature

_____/_____/_____
Date

Physicians Name (please print)

Telephone Number/Fax Number