Beautiful Smiles Family Dental Center
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Medical Evaluation for Sedation or General Anesthesia

Patient: ______________________ Date of Procedure: ______________

Physician: ______________________ Physician's Telephone Number: __________

Please perform a "Physical and History" as age appropriate, and fax the findings to this office.

History:

Allergies: ____

Asthma: __________ Pulmonary Disease: ________ Smoking History: ________

Bleeding Tendency: ________ Diabetes: __________ Heart Murmur: ________

Blood Pressure Hx: ________ Immunizations to date: ______________

Previous Surgery: ______________ Previous Anesthesia: ______________

Neurologic Disorder: ______________________________________

Hemotologic Disorder: ______________ Hepatic, Renal Hx: ______________

Other Cardiac Hx: ______________________________________

Arthritis, Cervical Spine Tx: ______________ Family Hx: ______________

Other Medical Hx: ______________ Other Contributing Hx: ______________

Medications (Dose and Schedule):

____

____

____

Physical Examination:

Temp ______ Pulse ______ BP ______ Resp Rate ______ Height ______ Weight ______

Mental Status ________ Throat ________ Lungs ________

Skin ________ Dentition ________ Abdomen ________

Eyes ________ Neck ________ BMI ________

Ears ________ Chest ________ Back ________

Nose ________ Heart ________ Neurological ________

Please provide results for the following lab tests:

CMP ______ CBC ______ Coagulation Times/INR ______ Glycohemoglobin ______

Summary of Findings:

____

____

Is the patient physically cleared for Sedations/General Anesthesia: Yes ______ No ______

*Please provide the lab results with this completed form.

Physician's Name (Print): ______________ Physician's Signature: ______________

Date: ____________

*Diplomate, American Dental Board of Anesthesiology * Fellow, American Dental Society of Anesthesiology * American Society of Dentist Anesthesiologists*