ROCK ST

(office) 508.692.9548 (fax) 508.692.9549

This patient is scheduled to undergo IV sedation/anesthesia for a dental procedure. Please provide History & Recent Physical

Patient: _____ Physician: _____

MD Phone: _____

Date of Procedure: _____

MD Fax: _____

Date of Birth _____ Age: _____

History:

(-) if negative ***(+) if positive***

Allergies: _____ Previous Surgeries: _____

Asthma: _____ Previous Surgical Complication: _____

Pulmonary Disease: _____ Recent Exposure to Varicella: _____

Diabetes: _____ Seizure Disorder: _____

Heart Murmur: _____ Sickle Cell or Variant: _____

Heart Disease or Defect: _____ Other Hematological Abnormalities: _____

Other Conditions: _____ Family Disease of Bleeding, Muscle Disease or Anesthesia Complications: _____

Immunizations up to Date? _____ Yes _____ No Recent ASA: _____

Daily Medications? Dose and Schedule: _____

Physical Examination:

Vitals: Ht. _____ Wt. _____ Temp _____

Resp Rate _____ BP _____ HR _____

Mental Status: Throat: _____ Lungs: _____

Eyes: _____ Neck: _____ Abdomen: _____

Ears: _____ Chest: _____ Extremities: _____

Nose: _____ Heart: _____ Neurological: _____

Lab Data:

Hct: _____ Hgb: _____ UA: _____ Glucose: _____ Other: _____

Pre/Peri Operative Suggestions:

ANESTHESIA DEEMED TO BE OF MEDICAL NECCESSITY FOR SPECIFIC DENTAL PROCEDURE? ☐ *YES* ☐ *NO*

Signature: _____ MD Date: _____