History and Physical Form

Referring Dentist Name: Phone #: Fax#: **Date of Surgery:**

Patient Name: _____ DOB: _____ Age: _____

Note to provider: This must be completed no more than 30 days prior to date of procedure and must be completed in it's entirety.

Past Surgical Hx.: _____

Has there ever been any personal or family history of problems with anesthesia: YES / NO (circle one)

Adverse Anesthesia Reaction:
Malignant hyperthermia / nausea / vomiting / difficult to rouse /

other: _____

List any medications taken (include prescriptions, vitamins, herbal supplements, OTC, inhaled, topical, nutraceuticals)

_____

Allergies: None / if yes, (circle none or list list name and reaction)

_____

Please list any pediatric specialists treating the child (include phone #) _____

_____

Has the patient ever had any of the following health problems (please check and indicate any that apply in each category or check NONE):

General: ☐ NONE
☐ H/O Prematurity
☐ Congenital Syndromes _____

Neurological / Musculoskeletal ☐ NONE
☐ Seizures ☐ Motion Sickness
☐ Bipolar ☐ Autism
☐ ADHD ☐ Cerebral Palsy
☐ Syncope ☐ Muscular Dystrophy
☐ Panic Attacks/Depression/Anxiety (please circle)
☐ Other _____

Gastrointestinal ☐ NONE
☐ Reflux / GERD
Please circle - Crohn's Disease /Ulcerative Colitis/ Other IBD
☐ Other _____

Genitourinary ☐ NONE
☐ Urinary Track Infection (UTI)
☐ Date of last menses _____
☐ Other _____

Cardiovascular ☐ NONE
☐ Congenital Heart Disease: Type _____
☐ Dysrythmia _____
☐ Heart Surgery: Date _____ Type: _____
☐ Other _____

Pulmonary ☐ NONE
☐ Asthma (mild / severe)
☐ Flu Date: _____
☐ Pneumonia date: _____
☐ Recent URI /Cold (date of last symptoms_____)
☐ Congenital Pulmonary Disease _____
☐ Obstructive Sleep Apnea
☐ Other _____

Endocrine ☐ NONE
☐ Diabetes Type I
☐ Diabetes II
☐ Other _____

Hematologic ☐ NONE
☐ Anemia
☐ Sickle cell trait
☐ Sickle cell disease
☐ Hemophilia
☐ HIV / AIDS
☐ Other _____

Social History: ☐ NONE
Please circle - Exposure to Tobacco / tobacco use / Vape
☐ Alcohol
☐ Recreational/street drugs Date last use _____

(MUST COMPLETE IN IT'S ENTIRETY)

Ht: _____ **Wt:** _____ **BMI:** _____ **T**_____ **BP**_____ **P**_____ **R**_____ **O_2 Sat** _____

Physical Exam	Normal	Explain Abnormal Findings	Physical Exam	Normal	Explain Abnormal Findings
HEENT			Musculoskeletal		
Neurological			GI		
Cardiovascular			GU		
Pulmonary			Other		

Pertinent Laboratory Studies: _____

☐ **This patient is medically cleared for a surgical procedure in an ambulatory surgery center.**

_____

Provider signature - credentials **Print Name** **License # or Office Stamp** **Date**

Update to H&P if completed within 30 days prior to prior to admission, outpatient visit, registration or procedure requiring anesthesia services

Immediate Preoperative Assessment

☐ I have examined this patient and there are no significant health changes.
☐ I have examined this patient and significant health changes are: _____

_____

Provider Signature - credentials Print Name Date Time

Revised: 09/24/2019