PRE-OPERATIVE PHYSICAL EXAM FORM

FAX # (855) 944-5438
EMAIL: SEDATION@UPWARDSMILES.COM

Name: _____

DOB: _____

The child must be examined and the history and physical examination must be documented within ninety (90) days prior to an office-based general anesthesia procedure by a state licensed clinician.

Date of exam: _____

Surgical procedure planned: Restorative Dental Care under General Anesthesia in an Office-Based Setting

Significant medical history: _____

HISTORY

Allergies: ☐ No Drug/Contrast Allergy ☐ No Food Allergy ☐ No Product/Latex Allergy ☐ Unable to Obtain Allergy Information

Specifics: _____

	No	Yes	Comments
Current medications:	☐	☐	
Steroids past 6 months:	☐	☐	
Previous anesthesia:	☐	☐	
Recent infection/exposure:	☐	☐	
Immunizations needed:	☐	☐	
Seizures:	☐	☐	
Croup/wheezing:	☐	☐	
Bleeding tendency: Patient:	☐	☐	
Family:	☐	☐	

PHYSICAL EXAMINATION

Ht _____in Wt _____lbs Temp _____°F Pulse _____ BP_____ / _____

BMI_____

	NL	ABNL	Comments
Appearance:	☐	☐	
Skin/lymph:	☐	☐	
Head, eyes, ears, nose, throat:	☐	☐	
Teeth:	☐	☐	
Heart:	☐	☐	
Lungs:	☐	☐	
Abdominal:	☐	☐	
Genitalia:	☐	☐	
Extremity:	☐	☐	
Neurologic:	☐	☐	

Special Instructions: _____

ARE THERE ANY CONTRAINDICATIONS TO DENTAL CARE UNDER GENERAL ANESTHESIA: YES NO

Physician/Clinician Signature & Credentials Print Name Time Date

DTB0001