



Medical Clearance for General Anesthesia Low Risk Surgical Procedure

Patient Name:	Date:
Procedure: Dental exam and surgery under general anesthesia	
Date of surgery:	

To whom it may concern,

This patient is seeking to be treated under General Anesthesia for a low risk surgery. Please complete the enclosed Medical Clearance form and fax or scan the completed H&P and all accompanying documents (blood tests, EKG's, etc, as recommended by PCP and any relevant specialists) to:

**The Dental Surgery Center of DC
1220 Caraway Ct.
Upper Marlboro, MD. 20774
Phone: (301) 494- 3000
Fax: (301) 494-3333
Email: smile@dentalsurgerydc.com**

If you should have any questions or concerns, please feel free to contact us.

Regards,
The Dental Surgery Center of DC

Thank you

History and Physical for Low Risk Surgery under General Anesthesia

Patient Name: _____ **DOB:** _____ **Date:** _____

Sex	Race	Age	Height	Weight	BMI	BP	Pulse	Resp	Temp

Review of Systems (Check ALL that apply OR check None)

- | | | | |
|--|---|---|---|
| Cardiovascular: <input type="checkbox"/> None
<input type="checkbox"/> Congenital Heart dz
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Angina/Chest Pain
<input type="checkbox"/> MI/CAD
<input type="checkbox"/> CHF
<input type="checkbox"/> Arrhythmia/palpitations
<input type="checkbox"/> Pacemaker/AICD
<input type="checkbox"/> Valvular Disease
<input type="checkbox"/> CABG/Cardiac Surgery
<input type="checkbox"/> Coronary Stent
<input type="checkbox"/> Poor Exercise Tolerance
<input type="checkbox"/> PVD
<input type="checkbox"/> Other _____ | Pulmonary: <input type="checkbox"/> None
<input type="checkbox"/> Asthma/RAD
<input type="checkbox"/> COPD/Emphysema
<input type="checkbox"/> Smoking History
<input type="checkbox"/> SOB
<input type="checkbox"/> Sleep Apnea/Snoring
<input type="checkbox"/> CPAP
<input type="checkbox"/> Cough
<input type="checkbox"/> Wheezing
<input type="checkbox"/> PND/Orthopnea
<input type="checkbox"/> URI
<input type="checkbox"/> Other _____ | Neurological: <input type="checkbox"/> None
<input type="checkbox"/> TIA or stroke
<input type="checkbox"/> Seizures
<input type="checkbox"/> Cerebrovascular Disease
<input type="checkbox"/> Dementia
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Neuromuscular Disease
<input type="checkbox"/> Syncope
<input type="checkbox"/> Shunt
<input type="checkbox"/> Other _____ | Other: <input type="checkbox"/> None
<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> Reflux
<input type="checkbox"/> Hepatitis Type _____
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Recent Steroid Use
<input type="checkbox"/> Obesity
<input type="checkbox"/> Diabetes Type I
<input type="checkbox"/> Diabetes Type II
<input type="checkbox"/> Other _____ |
| Hematologic: <input type="checkbox"/> None
<input type="checkbox"/> Anemia
<input type="checkbox"/> Sickle Cell/ or Trait
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Other _____ | GYN: <input type="checkbox"/> None
<input type="checkbox"/> Pregnant
<input type="checkbox"/> LMP _____ | Anesthesia Airway: <input type="checkbox"/> None
<input type="checkbox"/> Family Hx Anest issues
<input type="checkbox"/> Previous Anest issues
<input type="checkbox"/> Other _____ | Pediatrics: <input type="checkbox"/> Normal
<input type="checkbox"/> Recent URI/Illness
<input type="checkbox"/> Developmental Delay
<input type="checkbox"/> Prematurity
<input type="checkbox"/> Congenital Anomaly
<input type="checkbox"/> Other _____ |
| | Psychological: <input type="checkbox"/> None
<input type="checkbox"/> Autism or <input type="checkbox"/> Asperger's
<input type="checkbox"/> PDD or NOS
<input type="checkbox"/> ADHD or ADD
<input type="checkbox"/> Other _____ | Kidney/Renal: <input type="checkbox"/> None
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Other _____ | |

Current Medications

Medication: _____	Dosage: _____	Frequency: _____	
Medication: _____	Dosage: _____	Frequency: _____	
Medication: _____	Dosage: _____	Frequency: _____	

Allergies/RXN
Medication/Seasonal/Foods

Surgical Hx: _____

General Appearance: _____

HEENT: PERRLA EOMI No Lymphadenopathy No JVD O/P MNL Thyroid Abnormal _____

Cardiovascular: RRR S1S2 S3 S4 Abnormal _____

Pulmonary: Lungs CTA B/L Abnormal _____

GI: Abd Benign-Normoactive BS No Hepatosplenomegaly Abnormal _____

Extremities: No Clubbing No Cyanosis No Edema Abnormal _____

Musculoskeletal: NML Muscle Tone NML Strength Abnormal _____

Neurological: CN II-XII DTR Intact and equal bilaterally NML Mental Status Abnormal _____

**I certify I have completed the patient's history and physical.
I clear this patient for General Anesthesia.**

Signature: _____

Date: _____

Doctor Name: _____

Phone #: _____ **Fax#:** _____

Office Name: _____