



Dedicated to make the dental experience for your patients, comfortable and anxiety free, since 1978

ANESTHESIA REGISTRATION INSTRUCTIONS

Updated 5/9/2020

Dear Dental Office Staff:

This is an **Intake Packet** for patients whom you are requesting general anesthesia for. Please print this out for your patients to fill out. This packet consists of the following items:

1. Introduction Letter to Patients
2. Medical History Form
3. Financial Information and Consent
4. Anesthesia Informed Consent – Office Copy
5. Anesthesia Informed Consent – Patient Copy
6. Pediatrician H&P Form

Please make sure all following has been completed (check-off list)

- Patient has completed and signed all forms
- You have filled out the top portion of the H&P form
- Patient has been given their copies of the Consent Form
- Patient has been given the H&P form to take to their pediatrician
- Please email all items labeled “**Office Copy**” to lora@ambulatoryda.com. Please retain these copies for us.

Please call us with any questions for you or your patients. We’d be glad to help anytime.

- Contact: Lora at lora@ambulatoryda.com or (276) 492-0120

Yours,

Ambulatory Dental Anesthesia Associates



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Patient Copy

PATIENT REGISTRATION PACKET

Updated 5/9/2020

Dear Parent or Legal Guardian:

Welcome to Ambulatory Dental Anesthesia Associates. The following will provide you with instructions on how to complete your registration process for your child's anesthesia. It will also give you information about the upcoming anesthesia appointment. This packet consist of the following:

1. Medical History Form
2. Financial Information and Consent
3. Anesthesia Informed Consent – Our Copy
4. Anesthesia Informed Consent – Your Copy
5. Pediatrician History and Physical Form
 - **This form is for you to take to your child's pediatrician. Please have the pediatrician complete the form and email it to us prior to the day of your child's appointment.**

Prior to the Appointment

1. Make an appointment with the pediatrician, and have them complete the **Pediatrician History and Physical Form**
2. Review the **Informed Consent Form**. Call or email us if you haven't received or have lost your copy.
3. Jot down any questions you may have about your child's anesthesia
4. Call or email us with your questions

Day of the Appointment

1. Come with more questions. Questions are highly encouraged, as it will help you decide whether the proposed anesthesia is still the right option for your child.
2. Make sure your child is dressed comfortably. Loose pajamas are encouraged, since tight clothing can be uncomfortable for your child.
3. Make sure your child has short sleeves underneath. This will make it easier to place the IV and monitors.
4. It's a good idea to have diapers on, especially if your child has not been potty trained, as he or she will be receiving a lot of fluids to keep him or her hydrated.
5. Bring your child's favorite blanket, as it will help keep him or her warm. Also your child will feel much more at ease having something familiar with him or her.
6. Please remove nail polish on at least one finger, as nail polish may interfere with monitor readings.
7. Be sure that your child drinks lots of water prior evening to stay hydrated.
8. Lastly and most important: Make sure your child has **NOTHING TO EAT OR DRINK PAST MIDNIGHT**. This is **VERY important**, as any food or drink the stomach during anesthesia can result in **serious and fatal complications**.

Please contact us anytime if you have any questions about your child's upcoming anesthesia. You may contact us via email at lora@ambulatoryda.com or by phone at (276) 492-0120. We look forward to providing an excellent anesthesia experience for you and your child.

Yours,

Ambulatory Dental Anesthesia Associates



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MEDICAL HISTORY FORM

Updated 5/9/2020

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____ Date of Birth _____

Sex: Male Female

Height (inches) _____ Weight (pounds) _____

PEDIATRICIAN INFORMATION

Full Name _____ Phone Number _____

Address _____

Last Visit _____

Reason for Visit _____ Results of Visit _____

Is your child under the care of any other physician(s)? Provide name, address, and reasons below: _____

MEDICAL HISTORY

Please list all of your child's medical conditions: _____

Please list all medications your child is currently taking: _____

Please list all of your child's allergies, and indicate what type of reaction he or she gets from each of them: _____

PREVIOUS MEDICAL HISTORY

Please indicate all of your child's previous surgeries: _____

Please indicate all of your child's previous hospitalizations: _____



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MEDICAL HISTORY FORM

Updated 5/9/2020

Has your child been under general anesthesia? Yes No

Is there a history of adverse reaction to anesthesia in the family, including your child? Please describe: _____

Please list any medical information about your child which you have not indicated above: _____

REVIEW OF SYSTEMS

Has your child ever had any of the following?	Yes	No
Asthma		
Fainting Spells		
Seizures		
Heart Murmurs		
Abnormal Heartbeat		
Heart Defect at Birth		
Shortness of Breath (which required medical care)		
Frequent Nasal Congestion		
Frequent Snoring		
Running out of breath during sleep		

ADDITIONAL INFORMATION

Is your child as healthy and active as average kids his or her age? No Yes

Was your child born prematurely? No Yes, my child was born at ____ wks

Is your child exposed to second hand smoke? No Yes

Is your child exposed to second hand marijuana or other drugs? No Yes

Please describe any other information about your child's medical history we should know about: _____

LEGAL GUARDIAN ATTESTATION AND SIGNATURE

I attest that I am the legal guardian in charge of making medical and legal decisions for the child identified herein. I further attest that information provided regarding my child's medical history is true and to the best of my knowledge. I understand that any false information may pose serious and even fatal risk to my child during anesthesia.

Name _____ Relationship to patient _____

Signature of Legal Guardian _____ Date _____



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FINANCIAL INFORMATION AND CONSENT

Updated 5/9/2020

PAYMENT TERMS

The fees for anesthesia services are determined by time, which may vary depending on the severity of dental disease, complexity of treatment, recovery time, etc.

The **anesthesia fee is: \$1,500 for the first 100 minutes of anesthesia time, plus \$220 for every 15 minutes thereafter.**

\$1,500 deposit must be paid prior to my child's anesthesia appointment.

INSURANCE CLAIMS INFORMATION

We are **out of network** with all insurance carriers and do not accept any insurance plans. However, we will help you maximize your insurance benefits by filing a claim for your payment. Please complete this form if you would like us to help submit the claim to your insurance company.

Name of Insured _____ Social Security Number _____

Insurance Carrier _____ Claim Address _____

Insurance ID _____ Group Number _____

Name of Patient _____ Relationship to Insured _____

MEDICAID INFORMATION

If you are covered by the State Medicaid, please provide your Medicaid information below.

Patient Name _____ Date of Birth _____

Medicaid State _____ Medicaid Number _____

REFUND TERMS

I understand that the anesthesia fees will be refunded if the appointment is cancelled due to safety concerns by the anesthesiologist. I understand that I am never financially obligated to undergo anesthesia, and that Ambulatory Dental Anesthesia Associates will never hold you financially liable to undergo any treatment.

LEGAL GUARDIAN ATTESTATION AND SIGNATURE

I agree to the payment terms and conditions described herein. I authorize Ambulatory Dental Anesthesia Associates to release my child's medical and dental records for the purpose of submitting insurance claims for anesthesia services.

Name _____

Signature _____ Date _____



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DENTAL ANESTHESIA INFORMED CONSENT

Updated 5/9/2020

The following is provided to inform you of the choices and risks involved with your child's dental treatment under **deep sedation and general anesthesia**. This information is presented to enable you to be better informed concerning his or her treatment options.

YOUR OPTIONS

Initials: _____ This consent form goes over the risks, benefits, alternatives associated with **deep sedation and general anesthesia in the dental office**. However, there are several other options which you may choose for your child's dental treatment.

1. No treatment - You are NOT obligated to accept your child's proposed dental treatment or anesthesia. You have a right to refuse the dental treatment, anesthesia, or both.
2. Local anesthesia - Your child will be fully awake, and will be given injection(s) to numb the treatment area.
3. Papoose board - Your child will be strapped down for the procedure, and will be given injection(s) to numb the treatment area.
4. Nitrous oxide sedation - Your child will be given "laughing gas" to help relax throughout the procedure.
5. Oral sedation - Your child will receive pills or syrup to help relax throughout the procedure.
6. Deep sedation - Your child will be asleep during the procedure, and may also be given injection(s) to numb the treatment area.
7. General anesthesia - Your child will be fully asleep during the procedure, and may also be given injection(s) to numb the treatment area. Breathing tube may be placed from the mouth or the nose to protect your child's airway, and to ensure that he or she is breathing properly.

Deep sedation and general anesthesia are done in the presence of a trained anesthesiologist, and may be provided in the **office or in the hospital**.

COMMON SIDE EFFECTS

Initials: _____ The following are some of the most frequent side effects of sedation and general anesthesia.

- Drowsiness: Your child will remain drowsy and groggy for the rest of the day. As a result, his or her physical coordination will be impaired.
- Impaired judgment: Your child's judgment will be impaired following anesthesia, which can be up to twenty-four (24) hours following anesthesia.
- Nausea and vomiting: Your child may experience nausea and vomiting following anesthesia, which occurs in about 15-30% of patients.
- Phlebitis: Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site. The inflammation usually resolves with local application of warm moist heat; however tenderness, discoloration, and a hard lump may be present up to a year.
- Sore throat: Your child may experience sore throat for a few days following anesthesia due to the presence of a breathing tube during anesthesia.



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DENTAL ANESTHESIA INFORMED CONSENT

Updated 5/9/2020

COMPLICATIONS AND RISKS

Initials: _____ Anesthesia carries certain risks. Although rare, serious complication may arise as a result of anesthesia which may include: serious allergic reaction, kidney injury, stroke, brain injury, heart attack, and death. Certain complications may require hospitalization.

Initials: _____ Dental injections also carries certain risks. These may include temporary or permanent numbness at the area of injection, temporary or permanent nerve damage at the area of injection, seizures, or heart attack.

Initials: _____ Risks of complications are generally the lowest with no anesthesia, and greatest with deep sedation and general anesthesia.

DIETARY RESTRICTIONS

Initials: _____ During anesthesia, **any food or liquid in the stomach can lead to life threatening complications** including brain injury and death.

Initials: _____ Your child **must not have anything to eat or drink starting midnight** before his or her appointment. You or a responsible guardian must closely monitor your child during this period to make sure he or she doesn't consume anything while unattended.

Initials: _____ I agree to monitor my child and to strictly enforce the dietary restrictions prior to the anesthesia appointment.

Exceptions:

- **Clear water** and **clear apple juice** may be consumed no less than **four (4) hours** prior to the anesthesia appointment.
- Morning **medications** may be taken with a tiny sip of **clear water**, just enough to swallow the pills.

PREGNANT AND NURSING PATIENTS

Initials: _____ **FEMALE PATIENTS:** Anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility of having an informed discussion with my child and letting the anesthesiologist know of any possibility of pregnancy or a confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. I also understand that I must inform the anesthesiologist if my child is a nursing mother.

CLEARANCE FOR ANESTHESIA

Initials: _____ Anesthesia clearance requires a careful review of your child's medical history and physical presentation. The anesthesiologist may require you to bring your child to the pediatrician before an appointment can be booked.



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DENTAL ANESTHESIA INFORMED CONSENT

Updated 5/9/2020

CLEARANCE FOR ANESTHESIA (CONTINUED)

Initials: _____ A medical clearance from the physician does not guarantee a clearance for the anesthesia. On the appointment day, the anesthesiologist will make the final determination based on careful assessment as to whether anesthesia appointment may proceed as planned.

Initials: _____ I understand that the anesthesiologist has the rights to cancel, postpone, or refuse anesthesia for **any risk or perceived risk which in his/her sole discretion** may outweigh the benefits of the anesthesia.

CHANGES IN HEALTH

Initials: _____ Any changes in your child's health, especially the development of a fever or cold, is very important. For your child's safety, he or she may be re-scheduled for another day. Please inform the office of any change in your child's health prior to the appointment.

DURING THE ANESTHESIA

Initials: _____ Once anesthetics have been administered to your child and during the course of the ensuing anesthesia, **you WILL NOT be allowed access to your child** until the anesthesiologist determines that your child is ready to be recovered with you.

Initials: _____ Your child will have monitors such as blood pressure cuff, heart beat monitor, oxygen monitor, and breathing monitor throughout the course of the anesthesia.

Initials: _____ Your child will have an IV placed into his or her vein. This is generally done after your child has fully fallen asleep.

Initials: _____ Your child will also receive a breathing tube through his or her nose. Your child will not be aware that this is happening.

Initials: _____ Once the procedure is finished, your child will start to wake up. Although different children may wake up differently, it is normal for children to wake up crying, confused, and upset. Your child will stay with you in the recovery area until deemed safe to go home by the anesthesiologist.

AFTER THE ANESTHESIA

Initials: _____ Your child will be drowsy for the remainder of the day. His or her physical coordination will be impaired. Thus, it is important that a responsible adult remain in the presence of your child at all times for twenty-four (24) hours following anesthesia. During this period, your child must not play outside, go to school, swim, exercise, play sports, ride the bicycle, or participate in any other activities which require physical coordination. Your child must not walk up and down the stairs without an assistance of a responsible adult.



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DENTAL ANESTHESIA INFORMED CONSENT

Updated 5/9/2020

USE OF STREET DRUGS

Initials: _____ Exposure to street drugs (marijuana, heroine, cocaine, etc.) is strictly forbidden for several days before and after anesthesia. The mixture of street drugs and anesthetic/sedative agents has resulted in very serious and even fatal complications. Please consult the anesthesiologist if your child is exposed to any street drugs.

AUTHORIZATION AND REQUEST TO PROVIDE ANESTHESIA

Initials: _____ I hereby authorize and request Chet J. Sokolowski, DDS / Eric Han, DDS to perform the anesthesia and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia, and that this is an independent function from the surgery/dentistry.

Initials: _____ I have been advised of and completely understand the risks, benefits and alternatives of local anesthesia, sedation and general anesthesia. I have had the ample opportunity to review the consent form, ask questions, request information, consider the risks and alternatives (including no anesthesia), and make an informed decision regarding the anticipated anesthesia. I am satisfied with the information given to me and I consent to anesthesia.

Initials: _____ I understand that there is no warranty and no guarantee as to any result and/or cure. It is also understood that the anesthesia services are completely independent from the operating dentist's procedure. The anesthesiologist assumes no liability from the surgery/dental treatment performed while under anesthesia, and that the dentist assumes no liability from the anesthesia performed.

LEGAL GUARDIAN ATTESTATION AND SIGNATURE

Note: If you have any further questions about the anesthesia or if you feel that you need more information, please contact us before you proceed. You may contact us via phone or email at (276) 492-0120 or lora@ambulatoryda.com.

I have read and understood the possible risks, benefits, and alternatives to sedation and general anesthesia for my child's procedure. I have had the ample opportunity to review the consent form, ask questions and make an informed decision about my child's anesthesia. I am satisfied with the information given, and I consent to the provision of all levels of anesthesia for my child.

Name _____

Signature _____ Date _____

ANESTHESIOLOGIST ATTESTATION AND SIGNATURE

I have explained all possible risks, benefits, and alternatives to the proposed anesthesia. The undersigned was given the opportunity to have all their questions answered to their satisfaction.

Signature _____ Date _____



ANESTHESIA CONSENT – PATIENT COPY

Updated 5/9/2020

The following is provided to inform you of the choices and risks involved with your child's dental treatment under **deep sedation and general anesthesia**. This information is presented to enable you to be better informed concerning his or her treatment options.

YOUR OPTIONS

This consent form goes over the risks, benefits, alternatives associated with **deep sedation and general anesthesia in the dental office**. However, there are several other options which you may choose for your child's dental treatment.

1. No treatment - You are NOT obligated to accept your child's proposed dental treatment or anesthesia. You have a right to refuse the dental treatment, anesthesia, or both.
2. Local anesthesia - Your child will be fully awake, and will be given injection(s) to numb the treatment area.
3. Papoose board - Your child will be strapped down for the procedure, and will be given injection(s) to numb the treatment area.
4. Nitrous oxide sedation - Your child will be given "laughing gas" to help relax throughout the procedure.
5. Oral sedation - Your child will receive pills or syrup to help relax throughout the procedure.
6. Deep sedation - Your child will be asleep during the procedure, and may also be given injection(s) to numb the treatment area.
7. General anesthesia - Your child will be asleep during the procedure, and may also be given injection(s) to numb the treatment area. Breathing tube may be placed from the mouth or the nose to protect your child's airway, and to ensure that he or she is breathing properly.

Deep sedation and general anesthesia are done in the presence of a trained anesthesiologist, and may be provided in the **office or in the hospital**.

COMMON SIDE EFFECTS

The following are some of the most frequent side effects of sedation and general anesthesia.

- Drowsiness: Your child will remain drowsy and groggy for the rest of the day. As a result, his or her physical coordination will be impaired.
- Impaired judgment: Your child's judgment will be impaired following anesthesia, which can be up to twenty-four (24) hours following anesthesia.
- Nausea and vomiting: Your child may experience nausea and vomiting following anesthesia, which occurs in about 15-30% of patients.
- Phlebitis: Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site. The inflammation usually resolves with local application of warm moist heat; however tenderness, discoloration, and a hard lump may be present up to a year.
- Sore throat: Your child may experience sore throat for a few days following anesthesia due to the presence of a breathing tube during anesthesia.

COMPLICATIONS AND RISKS

Anesthesia carries certain risks. Although rare, serious complication may arise as a result of anesthesia which may include: serious allergic reaction, kidney injury, stroke, brain injury, heart attack, and death. Certain complications may require hospitalization.



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ANESTHESIA CONSENT – PATIENT COPY

Updated 5/9/2020

Dental injections also carries certain risks. These may include temporary or permanent numbness at the area of injection, temporary or permanent nerve damage at the area of injection, seizures, or heart attack.

Risks of complications are generally the lowest with no anesthesia, and greatest with deep sedation and general anesthesia.

DIETARY RESTRICTIONS

During anesthesia, **any food or liquid in the stomach can lead to life threatening complications** including brain injury and death.

Your child **must not have anything to eat or drink starting midnight** before his or her appointment. You or a responsible guardian must closely monitor your child during this period to make sure he or she doesn't consume anything while unattended.

I agree to monitor my child and to strictly enforce the dietary restrictions prior to the anesthesia appointment.

Exceptions: 1) **Clear water** and **clear apple juice** may be consumed no less than **four (4) hours** prior to the anesthesia appointment. 2) Morning **medications** may be taken with a tiny sip of **clear water**, just enough to swallow the pills.

PREGNANT AND NURSING PATIENTS

FEMALE PATIENTS: Anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility of having an informed discussion with my child and letting the anesthesiologist know of any possibility of pregnancy or a confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. I also understand that I must inform the anesthesiologist if my child is a nursing mother.

CLEARANCE FOR ANESTHESIA

Anesthesia clearance requires a careful review of your child's medical history and physical presentation. The anesthesiologist may require you to bring your child to the pediatrician before an appointment can be booked. A medical clearance from the physician does not guarantee a clearance for the anesthesia. On the appointment day, the anesthesiologist will make the final determination based on careful assessment as to whether anesthesia appointment may proceed as planned. I understand that the anesthesiologist has the rights to cancel, postpone, or refuse anesthesia for **any risk or perceived risk which in his/her sole discretion** may outweigh the benefits of the anesthesia.

CHANGES IN HEALTH

Any changes in your child's health, especially the development of a fever or cold, is very important. For your child's safety, he or she may be re-scheduled for another day. Please inform the office of any change in your child's health prior to the appointment.

DURING THE ANESTHESIA

Once anesthetics have been administered to your child and during the course of the ensuing anesthesia, **you WILL NOT be allowed access to your child** until the anesthesiologist determines that your child is ready to be recovered with you.

Your child will have monitors such as blood pressure cuff, heart beat monitor, oxygen monitor, and breathing monitor throughout the course of the anesthesia. Your child will have an IV placed into his or her vein. This is generally done after



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ANESTHESIA CONSENT – PATIENT COPY

Updated 5/9/2020

your child has fully fallen asleep. Your child will also receive a breathing tube through his or her nose. Your child will not be aware that this is happening.

Once the procedure is finished, your child will start to wake up. Although different children may wake up differently, it is normal for children to wake up crying, confused, and upset. Your child will stay with you in the recovery area until deemed safe to go home by the anesthesiologist.

AFTER THE ANESTHESIA

Your child will be drowsy for the remainder of the day. His or her physical coordination will be impaired. Thus, it is important that a responsible adult remain in the presence of your child at all times for twenty-four (24) hours following anesthesia. During this period, your child must not play outside, go to school, swim, exercise, play sports, ride the bicycle, or participate in any other activities which require physical coordination. Your child must not walk up and down the stairs without an assistance of a responsible adult.

USE OF STREET DRUGS

Exposure to street drugs (marijuana, heroine, cocaine, etc.) is strictly forbidden for several days before and after anesthesia. The mixture of street drugs and anesthetic/sedative agents has resulted in very serious and even fatal complications. Please consult the anesthesiologist if your child is exposed to any street drugs.

AUTHORIZATION AND REQUEST TO PROVIDE ANESTHESIA

I hereby authorize and request Chet J. Sokolowski, DDS / Eric Han, DDS to perform the anesthesia and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia, and that this is an independent function from the surgery/dentistry.

I have been advised of and completely understand the risks, benefits and alternatives of local anesthesia, sedation and general anesthesia. I have had the ample opportunity to review the consent form, ask questions, request information, consider the risks and alternatives (including no anesthesia), and make an informed decision regarding the anticipated anesthesia. I am satisfied with the information given to me and I consent to anesthesia.

I understand that there is no warranty and no guarantee as to any result and/or cure. It is also understood that the anesthesia services are completely independent from the operating dentist's procedure. The anesthesiologist assumes no liability from the surgery/dental treatment performed while under anesthesia, and that the dentist assumes no liability from the anesthesia performed.

LEGAL GUARDIAN ATTESTATION AND SIGNATURE

Note: If you have any further questions about the anesthesia or if you feel that you need more information, please contact us before you proceed. You may contact us via phone or email at (276) 492-0120 or lora@ambulatoryda.com.

I have read and understood the possible risks, benefits, and alternatives to sedation and general anesthesia for my child's procedure. I have had the ample opportunity to review the consent form, ask questions and make an informed decision about my child's anesthesia. I am satisfied with the information given, and I consent to the provision of all levels of anesthesia for my child.



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Pediatrician's

PEDIATRIC HISTORY AND PHYSICAL FORM

Updated 5/9/2020

THIS PORTION TO BE COMPLETED BY DENTAL OFFICE STAFF

Patient Name _____ Date of Birth _____ Sex: Male Female

Name of the Dental Office _____

Dear Pediatrician,

Our mutual patient named above is scheduled for a dental surgical procedure under general anesthesia. Please provide a current full History and Physical and your opinion on whether the patient is medically optimized for an elective anesthesia. Please note that **this clearance request is for general anesthesia, and NOT for the dental procedure.** Please email the completed form to lora@ambulatoryda.com. Thank you.

MEDICAL HISTORY (Please write legibly)

Neuro/Muscular: _____ Cardiac: _____

Pulmonary: _____ Gastrointestinal: _____

Other: _____

Birth History: Full Term Premature (indicate week and birth weight) _____

Physical Activity Active Moderate Limited Low (wheelchair/bed bound)

Hospitalization or Surgery History: _____

Other Medical Conditions Not Mentioned Above: _____

REVIEW OF SYSTEMS

Neuro/Psych: Negative Positive (please describe) _____

Eyes / ENT: Negative Positive (please describe) _____

Cardiac: Negative Positive (please describe) _____

Pulmonary: Negative Positive (please describe) _____

GI/GU/Renal: Negative Positive (please describe) _____

Musculoskeletal: Negative Positive (please describe) _____

SOCIAL HISTORY

Any exposure to tobacco, second hand smoke, marijuana, or recreational drugs? No Yes



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Pediatrician's

PEDIATRIC HISTORY AND PHYSICAL FORM

Updated 5/9/2020

FAMILY HISTORY Diabetes Hypertension Heart Disease Cancer Other (describe)

Comments: _____

PHYSICAL EXAM - PLEASE REMEMBER TO CIRCLE UNITS

Height _____ (cm/in) Weight _____ (lbs/kgs) BP _____ HR _____ RR _____

General _____ Head and Neck _____

Heart _____ Lungs _____

Extremities _____ Pain Assessment (indicate location and duration) _____

MEDICATIONS AND ALLERGIES

Please indicate the name, dosage, frequency, and administration route of all prescribed medications

Please indicate the patient's allergies

LABS AND TESTS

Please include results from any labs or tests

ADDITIONAL COMMENTS

Please provide any other pertinent information regarding patient's medical history and physical exam

PEDIATRICIAN FINDINGS

I am a licensed physician in the jurisdiction where I have examined the patient named herein. Upon my examination of the patient, I have determined that the patient is Optimized Not optimized for an elective general anesthesia.

Name / Title _____ Signature _____ Date _____