Ambulatory Dental Anesthesia Associates
— VIGILANT —

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

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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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 _____