Special Smiles, Ltd

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PRE-OPERATIVE PHYSICAL EXAMINATION FOR DENTAL CARE UNDER GENERAL ANESTHESIA

A Primary Care Physician must complete all sections and return to Special Smiles, Ltd at least FOURTEEN (14) days prior to the scheduled dental surgery date. This physical will expire 60 days from the date signed. Thank You.

PATIENT NAME: _____	DATE OF SURGERY _____/_____/ _____**
Date of Birth: _____/_____/_____	

CURRENT MEDICATIONS

(Please list all medications, including Over the Counter medications. Attach additional pages if necessary)

Medication	Dosage	For the Treatment of

Please list all allergies to food, medication or latex. Include patient and/or family history of anesthesia complications:

Please describe any hospitalizations or changes in medical history over the past year: ☐ YES ☐ NO

CURRENT HEALTH STATUS/MEDICAL TREATMENTS/ISSUES

Please specify all conditions that were an issue within the last 12 months.

☐ ASTHMA	☐ YES ☐ NO	☐ MUSCULAR DISEASE	☐ YES ☐ NO
☐ APNEA /DYSPHAGIA	☐ YES ☐ NO	☐ TB/COPD/PNEUMONIA	☐ YES ☐ NO
☐ ANTI-COAGULANTS	☐ YES ☐ NO	Date of last /infiltrate	____/____/____
☐ AIRWAY PROBLEMS	☐ YES ☐ NO	☐ SEIZURE DISORDER	☐ YES ☐ NO
☐ BLEEDING DISORDERS	☐ YES ☐ NO	Change in Seizure ☐ Frequency ☐ Pattern ☐ Medication	
☐ CANCER	☐ YES ☐ NO	☐Other:_____	
☐ DIABETES ☐ TYPE 1	☐ TYPE 2	Date of Last Seizure	____/____/____
☐ HEART DISEASE	☐ YES ☐ NO	Hospitalized after seizure?	☐ YES ☐ NO
☐ HEPATITIS	☐ YES ☐ NO	☐ PEG TUBE FED	☐ YES ☐ NO
☐ HYPERTENSION	☐ YES ☐ NO	☐ SCOLIOSIS/ DEGREE OF CURVATURE _____	
☐ KIDNEY DISEASE	☐ YES ☐ NO	☐ SEXUALLY ACTIVE	☐ YES ☐ NO
☐ LIVER DISEASE	☐ YES ☐ NO	☐ WEIGHT GAIN/LOSS	☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE PROVIDE A COMPLETE DESCRIPTION FOR EACH CONDITION.

PATIENT NAME _____ **DATE:** _____/_____/_____

PLEASE PROVIDE A COMPLETE DESCRIPTION FOR EACH ABNORMAL/OMITTED CONDITION

GENERAL APPEARANCE	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
MENTAL STATUS	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
SKIN/HEENT:	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
HEENT:	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
LYMPH NODES	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
LUNGS	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
HEART	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
ABDOMEN	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
URINARY	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
EXTREMITIES	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
MUSCULO-SKELETAL	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
NEUROLOGY	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED

Temperature **B/P** **Pulse** **Resp.** **Height** **Weight**

I HEREBY CERTIFY THAT I HAVE EXAMINED THE NAMED PATIENT AND ATTEST THAT HE/SHE IS STABLE TO UNDERGO DENTAL SURGERY UNDER GENERAL ANESTHESIA. THIS PHYSICAL WILL EXPIRE 60 DAYS FROM THE DATE SIGNED.

_____ _____/_____/_____

Physicians Signature **Date**

_____ _____

Physicians Name (please print) **Telephone Number/Fax Number**