Special Smiles LTD.

Comprehensive dental care for persons with special needs

PRE-OPERATIVE PHYSICAL EXAMINATION FOR DENTAL CARE UNDER GENERAL ANESTHESIA

A Primary Care Physician must complete and return to Special Smiles, Ltd

Name: _____ **DOB:** ____/____/____

Ht _____ **Wt** _____ **T** _____ **HR** _____ **RR** _____ **BP** _____ **SpO_2** _____

ALLERGIES
☐ NKDA

Name of drug/food

_____

_____

_____

Reaction

_____

_____

_____

☐ Tape
☐ Latex
☐ Dye
☐ Other _____

PATIENT OR FAMILY HX OF ANES PROBLEMS ☐ None
☐ Malignant Hyperthermia/MH
☐ Pseudocholinesterase
☐ MTHFR

SURGICAL/ANES HX ☐ None
_____

_____

_____

_____

_____

_____

_____

_____

_____

CARDIOVASCULAR ☐ WNL
☐ Hypertension
☐ CAD
☐ MI *date* ____/____/____
☐ CHF
☐ PVD
☐ Afib
☐ Arrhythmia
☐ VSD/ASD
☐ METS<4
☐ Pulm HTN
☐ Pacemaker/ICD
☐ Valvular Heart Disease
☐ Cardiomyopathy
☐ Echo *date* ____/____/____

RESPIRATORY ☐ WNL
☐ Smoker
☐ THC
☐ Home O2
☐ Asthma
  ☐ Mild ☐ Mod ☐ Severe
☐ COPD
☐ Dyspnea
☐ Sleep Apnea
☐ CPAP
  ☐ Daily ☐ Occasionally ☐ Never
☐ Trach
☐ PNA *date* ____/____/____

Date of last infiltrate:
____/____/____

HEPATIC/GI/GU/RENAL ☐ WNL
☐ CRI
☐ Hemodialysis
☐ Last HD Rx _____
☐ GERD
☐ Dysphagia
☐ PEG
  ☐ Strict NPO
☐ Liver Disease
  ☐ Hepatitis

ENDOCRINE ☐ WNL
☐ DM Type I
☐ DM Type II
☐ SGLT2
☐ GLP-1
☐ Thyroid Disease
  ☐ Hyperthyroidism
  ☐ Hypothyroidism
☐ Adrenal Insufficiency

Medication inst prior to GA

_____

_____

_____

_____

_____

_____

_____

_____

_____

NEURO/ORTHO ☐ WNL
☐ IDD
☐ Nonverbal
☐ Wheelchair bound
☐ Stroke / TIA
☐ Neuromuscular Disease
  ☐ Cerebral Palsy
  ☐ Other _____
☐ Anxiety
☐ Autism
☐ Chromosomal Disorder
  ☐ Down Syndrome
  ☐ Other _____
☐ Seizure Disorder
  ☐ Change in frequency
  ☐ Change in pattern
  ☐ Change in medication
  Date of last seizure ____/____/____
☐ Other _____

OTHER ☐ None
☐ Substance Abuse
☐ Tobacco
☐ ETOH
☐ Anemia
☐ Sexually Active
☐ Thrombocytopenia
☐ Anticoagulant/Anti Platelet
  Hold how many days prior to SX _____
☐ Hospitalized in past year
  Date/Dx

_____

_____

_____

_____

_____

_____

PLEASE MAKE SURE TO ATTACH THE FOLLOWING

☐ Office Visit Notes ☐ Medication List ☐ Lab Work ☐ Diagnostic Test Results ☐ Hospital DC Paperwork

I HEREBY CERTIFY THAT I HAVE EXAMINED THE NAMED PATIENT AND ATTEST THAT HE/SHE IS STABLE TO UNDERGO DENTAL SURGERY UNDER GENERAL ANESTHESIA IN AN OUTPATIENT SETTING. THIS PHYSICAL WILL EXPIRE 90 DAYS FROM THE DATE SIGNED.

Physician's Signature _____ Phone Number _____

Physician's Name *(please print)* _____ Fax Number _____

DATE ____/____/____

2301 E. Allegheny Avenue, Suite 120, Philadelphia, PA 19134 • **P** 267-639-6250 • **F** 267-639-6270 • SpecialSmilesLtd.com • front.desk@specialsmilesltd.com