LAKESIDE
DENTAL SURGERY CENTER

History and Physical Form

Date of Surgery:

Referring Dentist or Practice Name:

Patient Name: _____ DOB: _____ Age: _____

Note to provider: This must be completed no more than 30 days prior to date of procedure and must be completed in its entirety.

Surgical History: _____

Hospitalizations: _____

Has there ever been any personal or family history of problems with anesthesia: YES / NO (circle one)

Adverse Anesthesia Reaction: Malignant hyperthermia / Nausea / Vomiting / Difficult to rouse / Other: _____

List any medications taken (include prescriptions, vitamins, herbal supplements, OTC, inhaled, topical, nutraceuticals)

_____

Allergies: YES / NO (circle one) If yes, list name and reaction: _____

Please list any pediatric specialists currently treating the child (include phone #): _____

Does the patient have a history of ANY of the following medical conditions or health issues?
Check all that apply in each category or check NONE.

General ☐ None
☐ H/O Prematurity: # of weeks at time of delivery ___
☐ Congenital Syndromes _____

Neurological / Musculoskeletal ☐ None
☐ Seizures ☐ Motion Sickness
☐ Bipolar ☐ Autism
☐ ADHD ☐ Cerebral Palsy
☐ Syncope ☐ Muscular Dystrophy
☐ Anxiety/Depression/Panic Attacks (please circle)
☐ Other _____

Gastrointestinal ☐ None
☐ Reflux / GERD
☐ Crohn's Disease / Ulcerative Colitis (please circle)
☐ Other IBD
☐ Other _____

Genitourinary ☐ None
☐ Urinary Tract Infection (UTI)
☐ Date of last menses _____
☐ Other _____

Cardiovascular ☐ None
☐ Congenital Heart Disease: Type _____
☐ Dysrhythmia
☐ Heart Surgery: Date _____ Type _____
☐ Other _____

Pulmonary ☐ None
☐ Asthma (mild / severe)
☐ Flu: Date _____
☐ Pneumonia: Date _____
☐ Recent URI / Cold: Date of last symptoms _____
☐ Congenital Pulmonary Disease
☐ Obstructive Sleep Apnea
☐ Other _____

Endocrine ☐ None
☐ Diabetes Type I
☐ Diabetes Type II
☐ Other _____

Hematologic ☐ None
☐ Anemia
☐ Sickle cell trait
☐ Sickle cell disease
☐ Hemophilia
☐ HIV / AIDS
☐ Other _____

Social History ☐ None
☐ Exposure to tobacco / tobacco use / vape (please circle)
☐ Alcohol use
☐ Recreational / street drug use: Date of last use _____

Must complete the following section in its entirety.

Height _____ **Weight** _____ **BMI Percentile** _____% **T** _____ **BP** _____ **P** _____ **R** _____ **O_2 Sat** _____

Physical Exam	Normal	Explain Abnormal Findings	Physical Exam	Normal	Explain Abnormal Findings
HEENT			Musculoskeletal		
Neurological			GI		
Cardiovascular			GU		
Pulmonary			Other		

Pertinent Laboratory Studies: _____

☐ **This patient is medically cleared for a surgical procedure in an ambulatory surgery center with general anesthesia.**

X _____

Provider Signature – credentials Print Name License # and Office Stamp Date

Update to H&P if completed within 30 days prior to admission, outpatient visit, registration, or procedure requiring anesthesia services.

Immediate Preoperative Assessment

☐ I have examined this patient and there are no significant health changes.
☐ I have examined this patient and significant health changes are: _____

This Section for Surgery Center's Use Only

Provider Signature – credentials Print Name License # and Office Stamp Date

To return, please scan and email to navigator@lakesidedentalsurgerycenter or fax to (904) 306-1351.