

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 _____
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Must complete the following section in its entirety.

Height _____ **Weight** _____ **BMI Percentile** _____ % **T** _____ **BP** _____ **P** _____ **R** _____ **O₂ 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.com or fax to (904) 306-1351.