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PRE-OPERATIVE PHYSICAL EXAMINATION

Dear Doctor: Today's Date: _____

We are directing patient: _____ Date of Birth: _____

for a pre-operative History & Physical examination. The plan is for complete Oral & dental Rehabilitation under General Anesthesia in our facility. Completion of this form will assist our Anesthesiologists in determining clearance for this patient. **Include current labs to support this process.**

Physical Exam: Age_____ Ht_____ Wt_____ BMI_____ Allergies_____

Vitals: Temp _____ B/P_____ P_____ RR _____ Sats_____

General Appearance: --------	Normal/Abnormal	_____	DX: _____
Eyes: ----------	Normal/Abnormal	_____	_____
Nose: ----------	Normal/Abnormal	_____	_____
Pharynx: ----------	Normal/Abnormal	_____	_____
Tonsils: ----------	Enlarged 1+ 2+ 3+	_____	_____
Lymph Nodes: ----------	Normal/Abnormal	_____	_____
Neck: ----------	Normal/Abnormal	_____	_____
Heart: ----------	Normal/Abnormal	_____	_____
Chest: ----------	Normal/Abnormal	_____	_____
Lungs: ----------	Normal/Abnormal	_____	_____
Abdomen: ----------	Normal/Abnormal	_____	_____
Extremities: ----------	Normal/Abnormal	_____	_____
Skin: ----------	Normal/Abnormal	_____	_____
Neuro: ----------	Normal/Abnormal	_____	_____

Complaints/problems/Abnormality: _____

_____

_____

Current Medications: _____

_____

Labs: _____ Completed / Pending

Narrative: _____

_____

_____

By signing this form, I attest that I am a licensed Practitioner in the State of California

Date: _____ Physician Name: _____ MD / FNP / PA

Admitting Privileges at _____.

Hospital Name