SoCal Sleep Dentistry

Preoperative History & Physical Exam

Patient Name: _____

Height: _____ BMI: _____ DOB: _____

Weight: _____ Sex: _____ Age: _____

Medical History Please circle within normal limits (WNL) or describe any deviation from WNL.

General:	WNL	_____
Neuro/Psychiatric:	WNL	_____
Cardiac:	WNL	_____
Pulmonary:	WNL	_____
Hematology/Bleeding history:	WNL	_____
Endocrine:	WNL	_____
Musculoskeletal:	WNL	_____
Other:	WNL	_____

Physical Assessment

Eyes:	WNL	_____	Neck:	WNL	_____
Nose:	WNL	_____	Heart:	WNL	_____
Oral Cavity:	WNL	_____	Chest:	WNL	_____
Throat:	WNL	_____	Abdomen:	WNL	_____

Medications (attach list if necessary): _____

Surgical history (attach list if necessary): _____

Allergies (attach list if necessary): _____

Anesthetic, Family, and Social History

Has the patient ever had IV sedation or general anesthesia? Circle one: YES NO

Is there any family history of complications with anesthesia? Circle one: YES NO

List any other pertinent family history (cardiac, pulmonary, bleeding disorders): _____

Are there any smokers in the household? Circle one: YES NO

Adult Patients	Alcohol Use: Yes/No If yes, # drinks per day___	Tobacco Use: Yes/No If yes, type of tobacco and describe (e.g. packs per day)	Drug Use Yes/No If yes, describe drugs used and frequency

Please attach any recent lab work or studies that the patient has received (e.g. EKG, echo, HbA1c level, etc.) Are there any contraindications to this patient receiving IV sedation/general anesthesia? Circle one: YES NO (If yes, please explain)

Reviewing Physician's Name: _____

Office Phone Number: _____

Office Fax Number: _____

Physician's Signature: _____

Date of Exam: _____