Perioperative Medical Assessment

Date ____________________

Dear Doctor. The patient presents for dental procedures under general anesthesia.

Patient Name:___________________________________DOB: ________________Age:__________ Gender______________

Allergies:____Is this patient immunocompromised? Y / N

Past Medical History:____
____
____
____

Past Surgical History: ____

Medications: ____
____
____

Tobacco (Pack Years) ___ETOH/Rec Drugs:_______Malignant Hyperthermia: Y / N Functional Capacity (METS)________

Is this patient anticoagulated? If yes, please provide appropriate labs, perioperative recommendation for dental extractions and implants: ____

Is this patient followed by a cardiologist? Y / N. Please attach cardiology findings to this form.

Does this patient see any other medical specialists? If yes, please attach names and contact info of the specialists
Name______________________________Phone Number ____________________________Specialty____________________
Name______________________________Phone Number ____________________________Specialty____________________
If this patient sees more specialists, please attach on separate paper.

Review of Systems

CNS__________Cardiovascular_______________Respiratory__________________GI____________Hematologic__________

Endocrine____________GU___________Neuromuscular ______________Dermatologic________________Other_________

Physical Exam

HR: BP: SpO2: Temp: Height (cm)__________Weight(kg)__________BMI__________

Gen__________HEENT_______________Cardiovascular______________________Respiratory__________________

GU___________GI/Abdo______________Neurologic_________________________MSK________________________

Please provide most recent labs (If applicable): CBC, BMP, Coagulation, HbA1C, EKG

Is this patient optimized to undergo general anesthesia for dental procedures Y / N
Is this patient at **low risk** for non – dental complications Y / N

Additional Recommendations: ____
____

Print Name (MD)____Signature (MD) ___________________________________
Please Fax or Email this form to Safe Smile Dental Anesthesia

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