

# Pre-Operative History and Physical Outpatient Dental Procedures



Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**H&P not complete unless ALL areas are addressed.**

ID: This is a \_\_\_\_\_ year old (male/female) scheduled for general anesthesia or IV sedation to facilitate Dental Rehabilitation. Dental work will be as per Dr. \_\_\_\_\_ records and as indicated once a thorough dental exam is conducted under anesthesia. Informed consent will be obtained by the dentist.

Date of Surgery \_\_\_\_\_

Medical History \_\_\_\_\_

Chronic Health Problems \_\_\_\_\_

Current Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Recent Illnesses (none) \_\_\_\_\_

Perinatal Problems (none) \_\_\_\_\_

Vaccinations (up to date) \_\_\_\_\_

Previous surgeries/anesthesia (none) \_\_\_\_\_

Any history of asthma/bronchitis/pneumonia? NO YES

Any history of nausea/vomiting/diarrhea in past 3 days? NO YES

Has this child or any of his/her blood relative ever

had a serious reaction to an antibiotic? NO YES

Physical Exam: Weight \_\_\_\_\_ Height \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_ BP \_\_\_\_\_

Eyes: \_\_\_\_\_

Head: \_\_\_\_\_

Ears: Right (unable to see due to wax/good light reflex) \_\_\_\_\_

Left (unable to see due to wax/good light reflex) \_\_\_\_\_

Nose: \_\_\_\_\_

Throat: (Pharynx noninjected) \_\_\_\_\_

Neck: (shotty nodes palpated/no palpable nodes) \_\_\_\_\_

Lungs: \_\_\_\_\_

Heart: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Other: \_\_\_\_\_

Problem List: 1. Dental Caries requiring dental rehabilitation

2. \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
NP/PA Signature  
(must have MD co-sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time  
**Yellowstone Family Dentistry**  
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\_\_\_\_\_  
Physicians Printed Name

\_\_\_\_\_  
NP/PA Printed Name

Patient Information