PLEASE HAVE YOUR CHILD'S PHYSICIAN RETURN THIS FORM TO OUR OFFICE ON THE SAME DAY AS THE APPOINTMENT
FAX: 512-869-4166 EMAIL: GA@GTOWNKIDS.COM

HISTORY AND PHYSICAL EVALUATION FORM

PATIENT'S NAME: _____ PATIENT'S DOB: _____

Dear Physician:

This child is has a planned outpatient surgery date of _____ for dental rehabilitation with the use of general anesthesia at Oakwood Surgery Center. In order to ensure his or her safety, we ask that you complete and return this form to our office as soon as possible. Thank you in advance for your cooperation.

PERTINENT PAST MEDICAL HISTORY:

_____

PREVIOUS HOSPITALIZATIONS OR PROCEDURES UNDER GENERAL ANESTHESIA:

_____ _____ _____ _____
Procedure Date Procedure Date

CURRENT MEDICATIONS:

_____ _____ _____
Name/Dose/Frequency/Route Name/Dose/Frequency/Route Name/Dose/Frequency/Route

DRUG ALLERGIES:

_____
Medication Name(s)

PHYSICAL EXAMINATION:

	Normal	Abnormal	Explanation
General			
Head/Neck			
Lungs			
Cardiac			
Abdomen			
Genitourinary			
Extremities			
Neurologic			

ASSESSMENT AND RECOMMENDATION:_____
_____

_____PATIENT **IS** CLEARED FOR GENERAL ANESTHESIA **OR** **____**PATIENT **IS NOT** CLEARED FOR GENERAL ANESTHESIA

_____ _____
Physician's signature Date

_____ _____
Physician's name (printed) Phone number

4507 Williams Drive Gtownkids.com 512-869-4100