Dental Anesthesia Northwest, PLLC
208-818-6527 cell 208-676-1400 fax
Richard J. Montandon, DDS - Dentist Anesthesiologist

Name **DOB** **Patient Identification**	Pediatric Dental Surgery History & Physical, Consultation

All Dental patients having surgery must have a History and Physical completed by a Physician within 30 days prior to treatment under anesthesia.

To: _____ (Physician) Date: _____

Dear Physician: Your patient, _____, is scheduled for a dental surgical procedure. Please provide a current H&P and your evaluation of pertinent medical issues, including optimization of medical conditions and assessment of fitness for surgery and general anesthesia.

From: _____ Attending Surgeon/Pediatric Dentistry

Planned Surgical Procedure: _____ on **date:** _____

Physician's Offices: please complete all *marked* sections and **FAX both** pages to: 208-676-1400

Date of Exam: _____

Chief Complaint ☐ Dental Caries
☐ Other:

History of Present Illness ☐ Dental Disease

Medical History

Pulmonary ☐ NONE
☐ Asthma
☐ BPD
☐ Sleep Apnea
☐ Recent **URI** symptoms/date:

Cardiac ☐ NONE
☐ Congenital Heart Disease
Cardiac Tests (date/results):

Physical Ability
☐ Active, can exercise
☐ Moderate
☐ Limited
☐ Low (wheelchair/bed)

Neurologic/ Muscular ☐ NONE
☐ Developmental delay
☐ Cerebral Palsy
☐ Hyperactivity/ADHD
☐ Seizures
☐ Neuromuscular disease
☐ Syndrome:

Gastrointestinal ☐ NONE
☐ Reflux ☐ G/J tube ☐ Obesity

Other ☐ Blood diseases (sickle, hemophilia)

Birth History ☐ Full-term
☐ Premature @ _____ weeks Birth Weight: _____

Surgical History

Review of Systems

Eyes/ENT	Neg/ Pos :	Musc/Skel	Neg/ Pos :
Cardiac	Neg/ Pos :	Pulmonary	Neg/ Pos :
GI/GU	Neg/ Pos :	Neuro/Psych	Neg/ Pos :

Social History

Parent/ Guardian: _____
Lives with: _____
Tobacco: N Y Second Hand Smoke
Other:

Family History

☐ Diabetes ☐ Heart Disease
☐ Hypertension ☐ Cancer
☐ Other:

Name DOB **Patient Identification**	

Physical Exam Vital Signs: HR BP RR Weight Height

General: Heart: Lungs: Extremities:

Pain Assessment 0 (none) to 10 (worst) Location: Duration:

Medications

Allergies ❑ NKDA

Labs/Tests ❑ **NONE**

Pediatrician *Assessment and Plan*

❑ Adequate medical condition for proposed surgery

***Required :** Patient is a good candidate for general anesthesia **Yes No**

Reason:

Signature/Name: Date: Time:

Office Phone #:

******** Please FAX both pages to: 208-676-1400 ******

Day of Surgery Update (Anesthesiologist)

❑ Pediatrician H & P reviewed ❑ Medical Conditions noted:

❑ No critical medical changes, medically ready to proceed with surgery/anesthesia

Anesthesiologist Signature Printed name Date: Time:

Pediatric Dental Day of Surgery

Pediatrician H&P and Anesthesiology Day of Surgery update reviewed Notes:

Assistant Signature Printed name Date: Time:

Anesthesiologist Signature Printed name Date: Time:

* = required element

DANW 2/2017