

Take to Doctor's appointment prior to surgery

FAX COMPLETED FORM TO:



Black Hills Pediatric Dentistry, PC (605) 341-5757

SHORT FORM HISTORY & PHYSICAL

(May be used if H&P not dictated)

Patient Name \_\_\_\_\_ DoB \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Chief complaint / History of present illness \_\_\_\_\_

Past medical history \_\_\_\_\_

Past surgical history \_\_\_\_\_

History of Tonsils & Adenoids or Strep Throat \_\_\_\_\_ Quick Test  No  Yes

Bleeding disorders  No  Yes \_\_\_\_\_

Family History of Malignant Hypothermia  No  Yes (relation) \_\_\_\_\_

Drug and food allergies \_\_\_\_\_

Anasarca / Edema in last 30 days  No  Yes \_\_\_\_\_

Current medications \_\_\_\_\_

Review of systems

Respiratory \_\_\_\_\_

Vascular / Heart \_\_\_\_\_

Ortho / Neuro \_\_\_\_\_

GI \_\_\_\_\_

GU \_\_\_\_\_

EENT \_\_\_\_\_

Endocrine \_\_\_\_\_

Physical examination (specific to the procedure to be performed)

Mental status \_\_\_\_\_

Lungs \_\_\_\_\_

Heart \_\_\_\_\_

Murmur:  Yes  No Innocent:  Yes  No  Referred to: \_\_\_\_\_

HEENT \_\_\_\_\_

Neck / Lymph \_\_\_\_\_

Abdomen \_\_\_\_\_

Musculoskeletal \_\_\_\_\_

Neurological \_\_\_\_\_

Other findings \_\_\_\_\_

Diagnostic test results \_\_\_\_\_ Lab tests attached  No  Yes

➡ Pre-op clearance?  No  Yes (based on full physical and cardiopulmonary assessment, history, and review, this patient has been deemed suitable for general anesthesia.)

↻ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ PLEASE HAVE MD, PA, or NP SIGN OFF

For questions, please call Black Hills Pediatric Dentistry at (605) 341-3068

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