NORTH CAROLINA HOSPITAL DENTISTRY

Pre-Operative History and Physical Form

To be completed by a Medical Physician: PA or Nurse Practitioner requires Physician Signature.

Patient First Name: _____ Patient Last Name: _____ DOB: _____

Diagnosis: --Select-- _____ Proposed Surgical Procedure: Dental Surgery under General Anesthesia

Surgeon: Dr.Vejay K. Ravindran DDS,MS Date of Surgery: _____ Today's Date: _____

Who is completing this form? First Name: _____ Last Name: _____

Title of Person Completing this form ex: (RN)_____

Medical History/ Review of Systems- Check Box if applicable

Cardiovascular ☐ none
- ☐ Hypertension
- ☐ Angina/Chest Pain
- ☐ MI/CAD
- ☐ CHF
- ☐ Arrhythmia/Palpitations
- ☐ Pacemaker/AICD
- ☐ Valvular Disease
- ☐ CABG/Cardiac Surgery
- ☐ Coronary Stent
- ☐ Poor Exercise Tolerance
- ☐ PVD
- ☐ Other

Pulmonary ☐ none
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Smoking History
- ☐ SOB
- ☐ Sleep Apnea
- ☐ CPAP
- ☐ Cough
- ☐ Wheezing
- ☐ PND/Orthopnea
- ☐ URI
- ☐ Other_____

Neuromuscular ☐ none
- ☐ TIA or Stroke
- ☐ Seizures
- ☐ Cerebrovascular Disease
- ☐ Dementia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Psychiatric Disorder
- ☐ Neuromuscular Disease
- ☐ Syncope
- ☐ Other _____

GI Endocrine ☐ none
- ☐ Hiatal Hernia
- ☐ Reflux
- ☐ Hepatitis Type ___
- ☐ Cirrhosis
- ☐ Thyroid Disease
- ☐ Recent Steroid Use
- ☐ Obesity
- ☐ Diabetes __ I __II
- ☐ Other _____

Hematologic ☐ none
- ☐ Anemia
- ☐ Sickle Cell Disease/Trait
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chemotherapy

GYN/GU Renal ☐ none
- ☐ Pregnant
- ☐ LMP_____
- ☐ Kidney Disease
- ☐ UTI
- ☐ Other

Anesthesia Airway ☐ none
- ☐ Family Hx Anesthesia Problems
- ☐ Previous Anesthesia Complications
- ☐ Other

Pediatrics ☐ none
- ☐ Recent Illness
- ☐ Prematurity
- ☐ Congenital Anomaly
- ☐ Apnea

Comments on Positives or Symptoms/Conditions Not Listed: _____

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Date:	Surgery:	Past Surgical History	Complications:

Social History: Smoking --Select-- Alcohol --Select-- Drugs --Select--

Family History: ☐ none contributory _____

Physician Name: _____ Date: _____

Physician Email: _____ Phone Number: (____)_____

Physician Signature: _____

Pre-Operative Physical Examination Form- Page 2

Patient First Name: _____ Last Name: _____ DOB: _____

PHYSICAL EXAM

Sex	Race	Age	Height	Weight	BP	Pulse	Resp	Temp

General Appearance _____

HEENT ☐PERRLA ☐EOMI ☐No Lymphadenopathy ☐No JVD ☐O/P MNL ☐Thyroid WNL ☐WNL
Abnormal:

Cardiovascular ☐RRR S1S2 ☐S3 ☐S4
Abnormal:

Pulmonary ☐Lungs CTA B/L
Abnormal:

GI ☐Abd Benign- Normoactive BB ☐No Hepatosplenomegaly
Abnormal:

Extremities ☐No Clubbing ☐No Cyanosis ☐No Edema
Abnormal:

Musculoskeletal ☐NML Muscle Tone ☐NML Strength
Abnormal:

Neurological ☐CN II-XII ☐DTR Intact and equal bilaterally ☐NML Mental Status
Abnormal:

Genitals/Rectum ☐Deferred ☐No Masses ☐Hemo Negative
Abnormal:

Assessment

☐Medical conditions optimized, further testing not recommended, patient may proceed directly to surgery
☐Further evaluation needed as follows: _____

_____

_____

Comments: _____

_____

_____

Physician Name: _____ Date: _____
Physician Signature: _____Phone Number: (____)_____
Physician Email: _____ Private Line: (____)_____

Please email this form to info@nchospitaldentistry.com or fax to 919-424-0170 attn: Dr. Vejay K. Ravindran
Questions: info@nchospitaldentistry.com
THANK YOU

NORTH CAROLINA HOSPITAL DENTISTRY