Dental Surgical Center of Medina, Inc

PATIENT NAME / DATE OF BIRTH

SHORT FORM HISTORY AND PHYSICAL EXAMINATION
(FOR DENTISTRY UNDER GENERAL ANESTHESIA)

*PLEASE FAX **ASAP** TO 330-800-9549*

Date of Examination _____

Chief Complaint _____
Present Illness _____
_____
_____
Family History _____
Past History and Hospitalizations _____
_____
_____
_____
_____
Birth and Neonatal History _____
Allergies _____ Medications _____
Bleeding Tendencies _____ DRUG REACTIONS _____
EENT _____
Cardio- Respiratory _____
Genito- Urinary _____
Gastro- Intestinal _____
Neurological _____

PHYSICAL EXAMINATION: **T** **P** **R** **BP** **HT** **WT** **SA**
General Appearance _____
Head _____ Eyes _____
Ears _____ Nose _____
Throat _____ Tonsils _____
Neck _____ Lungs _____
Heart _____ Pulses _____
Abdomen _____
_____
Genitalia _____ Rectal _____
Extremities _____ Neurological _____
_____
Impression or Admission _____
_____
Additional Information _____
_____

Examining Physician _____M.D. Attending Physician _____M.D.

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