



Medical History & Physical Review

Dear Doctor,

Your patient is scheduled for dental treatment under General Anesthesia on (date) . Please complete the history and physical examination form. For patients with a cardiac history please send us (if available) the following work, hemoglobin, electrolytes, creatinine and ECG. Any further information or commentary is appreciated. Please contact me if I may be of any assistance. Thank you

Patient Name:	Instructions for Parents/Guardians/Adult Patients 1. Please fill out information on the left. 2. Please bring this form to your primary care physician and ask to have it completed. 3. Please return this form no later than one week prior to your/your child's appointment for anesthesia via email: info@minnesotada.com or fax: 1-952-487-2638
Date of Birth:	
Guardian Name:	
Relationship to Patient:	
Address:	
Telephone # Day:	
Telephone # Evening:	
Dentist Name:	

Allergies:		Medications:	
FUNCTIONAL INQUIRY			
Cardiac	Murmur-Echo Required?	Respiratory	Other
Past Illnesses	Previous Surgeries		
FAMILY HISTORY			
Anesthesia Problems:		Other:	
Physical Exam		Physician Signature/Stamp Date: _____	
BP	Head & Neck		
Pulse	Heart		
Rhythm	Lungs		
CNS	Abdomen: GI, Liver/Kidneys		
Height	Musculoskeletal		
Weight			
Additional Comments:			

