Rockville Centre For Dentistry

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MEDICAL ASSESSMENT FOR DENTAL SURGERY AND/OR IV SEDATION

Patient Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **B.P.:** _____ / _____

Pulse: _____ **Temp:** _____ **Resp Rate:** _____ /min.

Sex: M / F / NB **Age:** _____ y.o. **Date of Exam:** _____

Brief Medical History: _____

_____

Current Medical Conditions: _____

_____

List of Current Medications & Dosages: _____

_____

_____

Medical Allergies: _____

Food Allergies: _____

Joint Replacement: _____

Premed for Dental Tx? If yes, medication & recommended dosage: _____

_____

Does the patient require a pause of anticoagulant medication? Y / N

If yes, name of Medication: _____

If yes, how many days before should they stop & how many days after should they resume?: _____

_____

Prior History of Anesthesia Reaction? Yes / No

If yes, explain: _____

Relevant Family History?: _____

_____

General Appearance/Physical Exam:

(_____) ALERT (_____) ORIENTED Notes: _____

Skin: _____ **HEENT:** _____

Abdomen: _____ **Genital:** _____

Rectal: _____ **Cardiac:** _____

Respiratory: _____ **Psych:** _____

Neuro: _____ **Extremities:** _____

Patient Habits:

Current Smoker: Y / N Former Smoker: Y / N PPD: _____

Alcohol Usage: **Daily / Social / Never** **Drinks Per Week:**_____
Recreational Drugs: **Y / N** **Former Drug User:** **Y / N**
If yes to above, please explain usage history:_____
Recent Tests & Results:

- **EKG/ECG** _____ **WNL**

HEART RHYTHM STRIP MUST BE INCLUDED
FOR DENTIST/ORAL SURGEON TO READ*

- **CBC** _____ **WNL**
- **BMP/CMP** _____ **WNL**
- **PT/PTT** _____ **WNL**
- **U/A** _____ **WNL**
- **CHEST XRAY** _____ **WNL**
- _____ _____ **WNL**

Is patient medically cleared for dental treatment/surgery/IV sedation? **Y / N**
Any recommendations or limitations? **Y / N**
If yes, please explain: _____

Doctors Name: _____ **Date:** _____

Doctors Signature: _____ **Tel:** _____

Doctors Office Stamp: