Patient Name:_____DOB:_____

MD:_____Office Phone #:_____Fax#_____

Past Medical History:_____

_____

Current Diagnosis:_____

Current Medications:_____

Current Lab/X-Rays/Ekg results:_____

Surgical History:_____

PLEASE CHECK EACH AREA AND DESCRIBE ABNORMALS BELOW:

Cardiac: ☐ WNL ☐HTN ☐Murmur ☐Active ☐Innocent
☐ASD ☐VSD(echo required for non-repairs) ☐Other

Respiratory: ☐WNL ☐Asthmatic ☐COPD ☐Chronic Infections
☐Aspirations Precautions ☐Airway Obstruction ☐Other

Neuro: ☐WNL ☐Seizures ☐Controlled ☐Uncontrolled Date of last Seizures _____

☐Shunt ☐Heat Injury ☐Cerebral Palsy ☐Visual Problems ☐Other

GI: ☐WNL ☐Other Endocrine: ☐WNL ☐Other Renal: ☐WNL ☐Other

Hepatic: ☐WNL ☐Other Musculoskelatal: ☐WNL ☐Other

For patients older than 50 years of age, please add: ☐Ekg ☐CXR ☐Electrolytes/CBC

Patient is cleared for dental surgery to be done under general anesthesia in an outpatient setting ☐ Yes ☐ No

Additional Comments/notes:_____

_____

_____ _____
Print MD Name MD Signature Date

INDIO SURGERY CENTER

46-900 Monroe Street, Suite B-201

Indio, California 92201

(760) 396-5733 fax (760) 396-5723

PRE-OP Medical Clearance for General Anesthesia