INDIO SURGERY CENTER

Patient Name: ddd _____ **DOB:** _____

MD: _____ **Office Phone:** _____ **Fax#:** _____

Past Medical History: _____

Current Diagnosis: _____

Current Medications: _____

Ht.: _____ **Wt.:** _____ **BMI:** _____ **Hemoglobin:** _____

Vaccinations Current: ☐ Yes ☐ No **PPD:** ☐ Positive ☐ Negative

Current Lab/X-Ray/EKG Results: _____

Surgical History: _____

Please Check Each Area and Describe Abnormals Below:

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

Respiratory: ☐ WNL ☐ Asthmatic ☐ COPD ☐ Chronic Infections ☐ Snores ☐ Sleep Apnea
☐ Aspiration Precautions ☐ Airway Obstruction ☐ Other

Neuro: ☐ WNL ☐ Seizures ☐ Controlled ☐ Uncontrolled Date of Last Seizure: _____
☐ Shunt ☐ Head Injury ☐ Cerebral Palsy ☐ Visual Problems ☐ Other

GI: ☐ WNL ☐ Other ***Endocrine:*** ☐ WNL ☐ Other ***Renal:*** ☐ WNL ☐ Other
Hepatic: ☐ WNL ☐ Other ***Musculoskeletal:*** ☐ WNL ☐ Other

Comments/Notes: _____

_____

Patient is cleared for dental surgery to be done under general anesthesia in an outpatient setting.

☐ **Yes** ☐ **No** (If 'No', please provide reasoning) _____

_____

Bill Simpkins

_____ _____ _____

MD Name (print) **MD Signature** **Date**

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