

HISTORY AND PHYSICAL PRE-OP FORM

NAME: _____ DOB: _____

DIAGNOSIS: **EARLY CHILDHOOD CARIES**

PRESENT ILLNESS: **PRE-OP ASSESSMENT-OUTPATIENT DENTAL SURGERY**

PAST HISTORY

ALLERGIES: _____

MEDICATIONS: _____

SURGERY: _____

FAMILY HISTORY NEGATIVE EXCEPT: _____

PHYSICAL EXAM:

HEIGHT: WEIGHT: TEMP: PULSE: RESP: B/P: ____/ ____

| | NORMAL | ABNORMAL | NA | ABNORMAL FINDINGS |
|---------------|--------|----------|----|-------------------|
| HEART | | | | |
| BREASTS | | | | |
| C/V SYSTEM | | | | |
| LUNGS | | | | |
| ABDOMEN | | | | |
| GENITALIA | | | | |
| M-S SYSTEM | | | | |
| NEUROLOGIC | | | | |
| PSYCHO-SOCIAL | | | | |

NORMAL=WITHIN NORMAL LIMITS ANY "ABNORMAL" WILL BE EXPLAINED

PHYSICIAN SIGNATURE

DATE / TIME

Form can be faxed to: 903-891-9339 Attn: Marky