Robert D. Elliott, DMD, MS **Cary Pediatric Dentistry** Julie R. Molina, DDS, MS
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--- PRE-ANESTHESIA/PROCEDURE ASSESSMENT—

PLEASE COMPLETE WITHIN 30 DAYS OF APPOINTMENT

Patient Name: _____ Dentist/Surgeon _____Procedure Date:___/___/_____
DOB: __/___/_____ Age: _____ Sex: ☐ M ☐ F
Ht: ____' ____ Wt:_____

HPI:	
PMH:	☐ NONE
PSH: :	☐ NONE
FAMILY:	☐ PROBS W/ANESTHESIA ☐ COANGULOPAHTY
SOCIAL:	☐ TOBACCO ☐ EtOH ☐ DRUG
ALLERGIES:	☐ NONE

REVIEW OF SYSTEMS:

WNL		*ABNORMAL/COMMENT*
☐	GENERAL	
☐	HEENT	
☐	NECK	
☐	CARDIOVASCULAR	
☐	PULMONARY	
☐	GI	
☐	GU	
☐	EXTREMITIES	
☐	SKIN	
☐	NEURO	

MEDICATIONS: (DOSE, ROUTE, FREQUENCY) ☐ NONE

PHYSICAL EXAM: _____ VITAL SIGNS: **B/P: _____ P: _____ RESP: _____TEMP: _____**

WNL	*ABN*		*WNL*	*ABN*		*WNL*	*ABN*		***FINDINGS:***
☐	☐	CONSTITUTIONAL	☐	☐	EYES	☐	☐	MUSCULOSKELETAL	
☐	☐	PSYCH	☐	☐	CARDIOVASC	☐	☐	NEURO	
☐	☐	NECK	☐	☐	RESPIRATORY	☐	☐	LYMPH	
☐	☐	ENT	☐	☐	GI	☐	☐	EXTREMITIES	
			☐	☐	GU				

ADDITIONAL COMMENTS: _____

_____ DATE _____ TIME _____:_____ AM/PM
PHYSICIAN SIGNATURE

_____
ADDRESS OF PEDIATRICIAN OFFICE PEDIATRICIAN'S PHONE NUMBER