PLEASE HAVE YOUR CHILD'S PHYSICIAN FAX THIS COMPLETED FORM TO OUR OFFICE AT (512) 869-4166. PLEASE RETAIN A COPY OF THIS COMPLETED FORM TO BRING WITH YOU TO YOUR CHILD'S SURGERY APPT.

History and Physical Evaluation Form

Date: _____

Child's Name: _____ **DOB:** _____

Planned Procedure: **Dental Rehabilitation on** ____/____/____

Pertinent Past Medicaid History:

_____

_____

Previous Hospitalizations/General Anesthesia (date/ hospital/ reason):

_____

_____

Medication (drug/dose/frequency/route):

_____

_____

Drug Allergies:

_____

_____

Physical Examination:

	Normal	Abnormal	Explanation
General	☐	☐	_____
Head/Neck	☐	☐	_____
Lungs	☐	☐	_____
Cardiac	☐	☐	_____
Abdomen	☐	☐	_____
Genitourinary	☐	☐	_____
Extremities	☐	☐	_____
Neurologic	☐	☐	_____

Assessment and Recommendations:

_____

_____

☐ **Yes, cleared for General Anesthesia** ☐ **No, further testing needed**

Physician's Signature: _____ **Date:** _____

Physician's Name: _____ **Phone:** _____