

## Medical Clearance for General Anesthesia

### Low Risk Surgical Procedure

Patient Name:	Date:
Procedure: <b>Dental exam and surgery under general anesthesia</b>	
Date of surgery:	

**To whom it may concern,**

This patient is seeking to be treated under General Anesthesia for a low risk surgery. Please complete the enclosed Medical Clearance form and fax or scan the completed H&P and all accompanying documents (blood tests, EKG's, etc, as recommended by PCP and any relevant specialists) to:

**Baltimore Surgery Center**  
**3421 Benson Ave, Suite G-100**  
**Phone: (410) 417-7777**  
**Fax: (410) 417-9999**  
**Email: smile@baltsurgery.com**

If you should have any questions or concerns, please feel free to contact us.

Regards,  
Baltimore Surgery Center

Thank you

## History and Physical for Low Risk Surgery under General Anesthesia

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Sex	Race	Age	Height	Weight	BMI	BP	Pulse	Resp	Temp

Review of Systems (Check ALL that apply OR check None)

<b>Cardiovascular:</b> __ None __ Congenital Heart dz __ Hypertension __ Angina/Chest Pain __ MI/CAD __ CHF __ Arrhythmia/palpitations __ Pacemaker/AICD __ Valvular Disease __ CABG/Cardiac Surgery __ Coronary Stent __ Poor Exercise Tolerance __ PVD __ Other _____	<b>Pulmonary:</b> __ None __ Asthma/RAD __ COPD/Emphysema __ Smoking History __ SOB __ Sleep Apnea/Snoring __ CPAP __ Cough __ Wheezing __ PND/Orthopnea __ URI __ Other _____	<b>Neurological:</b> __ None __ TIA or stroke __ Seizures __ Cerebrovascular Disease __ Dementia __ Osteoarthritis __ Rheumatoid Arthritis __ Psychiatric Disorder __ Neuromuscular Disease __ Syncope __ Shunt __ Other _____	<b>Other:</b> __ None __ Hiatal Hernia __ Reflux __ Hepatitis Type ____ __ Cirrhosis __ Thyroid Disease __ Recent Steroid Use __ Obesity __ Diabetes Type I __ Diabetes Type II __ Other _____
<b>Hematologic:</b> __ None __ Anemia __ Sickle Cell/ or Trait __ Bleeding Disorder __ Cancer __ Chemotherapy __ Other _____	<b>GYN:</b> __ None __ Pregnant __ LMP _____	<b>Anesthesia Airway:</b> __ None __ Family Hx Anest issues __ Previous Anest issues __ Other _____	<b>Pediatrics:</b> __ Normal __ Recent URI/Illness __ Developmental Delay __ Prematurity __ Congenital Anomaly __ Other _____
	<b>Psychological:</b> __ None __ Autism or __ Asperger's __ PDD or NOS __ ADHD or ADD __ Other _____	<b>Kidney/Renal:</b> __ None __ Kidney Disease __ Other _____	

**Current Medications**

**Allergies/RXN**  
Medication/Seasonal/Foods

Medication: _____	Dosage: _____	Frequency: _____	_____
Medication: _____	Dosage: _____	Frequency: _____	_____
Medication: _____	Dosage: _____	Frequency: _____	_____

**Surgical Hx:** \_\_\_\_\_

**Most recent Illness:** \_\_\_\_\_ **Date of illness:** \_\_\_\_\_

**General Appearance:** \_\_\_\_\_

**HEENT:** \_\_ PERRLA \_\_ EOMI \_\_ No Lymphadenopathy \_\_ No JVD \_\_ O/P MNL Thyroid Abnormal \_\_\_\_\_

**Cardiovascular:** \_\_ RRR S1S2 \_\_ S3 \_\_ S4 Abnormal \_\_\_\_\_

**Pulmonary:** \_\_ Lungs CTA B/L Abnormal \_\_\_\_\_

**GI:** \_\_ Abd Benign-Normoactive BS \_\_ No Hepatosplenomegaly Abnormal \_\_\_\_\_

**Extremities:** \_\_ No Clubbing \_\_ No Cyanosis \_\_ No Edema Abnormal \_\_\_\_\_

**Musculoskeletal:** \_\_ NML Muscle Tone \_\_ NML Strength Abnormal \_\_\_\_\_

**Neurological:** \_\_ CN II-XII \_\_ DTR Intact and equal bilaterally \_\_ NML Mental Status Abnormal \_\_\_\_\_

**I certify I have completed the patient's history and physical.**  
**I clear this patient for General Anesthesia.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Doctor Name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**Office Name:** \_\_\_\_\_