

TO OUR PATIENT'S ATTENDING PHYSICIAN:

_____ requires sedation for dental restorative treatment in our office.

We would appreciate your courtesy in completing a report of the physical examination.

Anesthetic: Oral Sedation

PHYSICAL EXAMINATION

Height _____ Weight _____ Temperature _____

Respirations _____ Pulse _____ Blood Pressure _____

CNS _____ LUNGS _____
 HEART _____ ABDOMEN _____

Additional Comments or Information: _____

Does this patient have any respiratory problems, asthma, any asthma-type symptoms, such as reoccurring bronchitis or wheezing? YES _____ NO _____ If yes, list symptoms and any medications taken: _____

Has there ever been an occurrence of sleep apnea? YES _____ NO _____

Do you feel this patient's physical condition is satisfactory for dental restorative treatment under sedation? YES _____ NO _____

Is the patient on any medication or regimen that you want continued under sedation? YES _____ NO _____
 If yes, please state medication, dosages, other: _____

Date _____ Physician Signature _____

Address _____