Drs. Wood, Dunlevy & Lombardozzi
PEDIATRIC DENTISTRY & ORTHODONTICS

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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_____

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