

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 \_\_\_\_\_