Ambulatory Dental Anesthesia of New York

Dr. Jason L. Joseph DMD PC M(516-236-9271) Fax(516-453-6005)

Medical Evaluation Form

The patient's physician must complete this Medical Evaluation Form and we ask that it done as close to the scheduled treatment day. Physicians please fill out this form as legible as possible and sign stating the patient's general health, past health, and/or current disease or illness. We understand there might be a need for additional pre-anesthetic lab work or additional consultation required - please indicate in form if that is needed. **Once Form is Done Please FAX TO: 516-453-6005: Parents Please Bring in Original Copy.**

General History

Patients Name:_____**Date**:_____ **Weight**:_____**Height**:_____

Date of Birth:_____: **Vitals**:_____/_____**Pulse**:_____**Temp**:_____**RR**:_____

General Summary of **Medical History**:_____

Medications:_____

Allergies:_____[ ]**NKDA**

Please Circle: SMOKING /ETOH ILLICIT/ DRUG USE Describe:_____

Past Surgeries:_____

Physical History

Overall General Appearance:_____

Head & Neck:_____**Tonsils**:_____

Cardiovascular:_____

Circle: Congenital Heart Disease CAD Arrhythmia Pacemaker AICD

Pulmonary:_____

Circle: Asthma Sleep Apnea COPD

Renal:_____

Gastro-Intestinal:_____

Circle: Reflux/GERD Dysphagia Dysmotility Hernia

Hepatic:_____

Endocrine:_____**Circle**: Thyroid Diabetes: Type:_____

Musculoskeletal:_____

Neurological:_____

Circle: Cerebral Palsy PDD ADD/ADHD Seizures Developmental Delay Neuropathy

Metabolic:_____

OB/GYN:_____

Lab Data/Radiological Studies:_____**HCG** (if approp)_____

Comments:_____

_____

Physician Name:_____ **Signature**:_____

Date:_____ **Contact Number**:_____