



## Medical Evaluation Cover Letter

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To whom it may concern:

Our mutual patient is scheduled for dental treatment with the aid of deep sedation and/or general anesthesia. Please provide us with the following medical evaluation and any other pertinent information you feel is important in providing optimal care for this patient.

After completing this form, please fax it to our office and ask the patient or guardian to bring the original copy to our office. Thank you for your cooperation and if you have any questions, please feel free to call our office coordinator line at (615)933-6652.

Sincerely,

Matthew Yezerski, DMD  
Dentist Anesthesiologist

Katie Bradford, DDS  
Dentist Anesthesiologist

Kristen Pelczar, DMD  
Dentist Anesthesiologist



# Medical Evaluation for Sedation or General Anesthesia

Please fax to (615) 777-3161

Patient: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Dentist Office: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Physician's Phone: \_\_\_\_\_  
Date of Procedure: \_\_\_\_\_

### History:

Allergies \_\_\_\_\_  
Asthma \_\_\_\_\_  
Pulmonary Disease \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Heart Murmur \_\_\_\_\_  
Heart Disease \_\_\_\_\_  
Other Conditions \_\_\_\_\_  
Immunizations up to date? Yes \_\_\_ No \_\_\_

Previous Surgery \_\_\_\_\_  
Previous Surgical Complications \_\_\_\_\_  
Recent Exposure to Varicella \_\_\_\_\_  
Sickle Cell Anemia or Variant \_\_\_\_\_  
Other Hematologic Abnormalities \_\_\_\_\_  
Family History of Bleeding, Muscle Disease, or Anesthesia Complications \_\_\_\_\_  
Recent ASA \_\_\_\_\_

**Medications:** \_\_\_\_\_

### Physical Examination:

T: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_ BP: \_\_\_\_\_ O2 SAT \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

Mental Status \_\_\_\_\_ Throat \_\_\_\_\_ Lungs \_\_\_\_\_  
Skin \_\_\_\_\_ Dentition \_\_\_\_\_ Abdomen \_\_\_\_\_  
Eyes \_\_\_\_\_ Neck \_\_\_\_\_ Extremities \_\_\_\_\_  
Ears \_\_\_\_\_ Chest \_\_\_\_\_ Back \_\_\_\_\_  
Nose \_\_\_\_\_ Heart \_\_\_\_\_ Neurological \_\_\_\_\_

### Lab Data: (If Indicated by Provider)

Hct \_\_\_\_\_ Hgb \_\_\_\_\_ Urinalysis \_\_\_\_\_  
Other \_\_\_\_\_

**Summary of Findings:** \_\_\_\_\_

### Suggestions Prior to Surgery:

- \_\_\_\_\_
- \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Provider Printed Name:** \_\_\_\_\_

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