CAPITAL CHILDREN'S
SURGERY CENTER

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1220 Caraway Ct, Suite 1050
Largo, MD 20774

# Medical Clearance for General Anesthesia

## Low Risk Surgical Procedure

| Patient Name: | Date: |
|---|---|
| Procedure:<br><br>**Dental exam and surgery under general anesthesia** | |
| Date of surgery: | |

**To whom it may concern,**

This patient is seeking to be treated under General Anesthesia for a low risk surgery. Please complete the enclosed Medical Clearance form and fax or scan the completed H&P and all accompanying documents (blood tests, EKG's, etc, as recommended by PCP and any relevant specialists) to:

**Capital Children's Surgery Center**
**1220 Caraway Ct, Suite 1050**
**Largo, MD 20774**
**Phone: (301) 494-3000**
**Fax: (301) 494-3333**
**Email: smile@capitalchildrens.com**

If you should have any questions or concerns, please feel free to contact us.

Regards,
Capital Children's Surgery Center

Thank you

# History and Physical for Low Risk Surgery under General Anesthesia

**Patient Name:** ________________________________________________ **DOB:** _________ **Date:** ______

| Sex | Race | Age | Height | Weight | BMI | BP | Pulse | Resp | Temp |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

Review of Systems (Check ALL that apply OR check None)

**Cardiovascular**: __ None
__ Congenital Heart dz
__ Hypertension
__ Angina/Chest Pain
__ MI/CAD
__ CHF
__ Arrhythmia/palpitations
__ Pacemaker/AICD
__ Valvular Disease
__ CABG/Cardiac Surgery
__ Coronary Stent
__ Poor Exercise Tolerance
__ PVD
__ Other____________

**Hematologic**: __ None
__ Anemia
__ Sickle Cell/ or Trait
__ Bleeding Disorder
__ Cancer
__ Chemotherapy
__ Other __________

**Pulmonary**: __ None
__ Asthma/RAD
__ COPD/Emphysema
__ Smoking History
__ SOB
__ Sleep Apnea/Snoring
__ CPAP
__ Cough
__ Wheezing
__ PND/Orthopnea
__ URI
__ Other__________

**GYN:** __ None
__ Pregnant
__ LMP ___________

**Psychological**: __ None
__ Autism or __ Asperger's
__ PDD or NOS
__ ADHD or ADD
__ Other____________

**Neurological**: __ None
__ TIA or stroke
__ Seizures
__ Cerebrovascular Disease
__ Dementia
__ Osteoarthritis
__ Rheumatoid Arthritis
__ Psychiatric Disorder
__ Neuromuscular Disease
__ Syncope
__ Shunt
__ Other__________

**Anesthesia Airway**: __ None
__ Family Hx Anest issues
__ Previous Anest issues
__ Other____________

**Kidney/Renal**: __ None
__ Kidney Disease
__ Other____________

**Other**: __ None
__ Hiatal Hernia
__ Reflux
__ Hepatitis Type ____
__ Cirrhosis
__ Thyroid Disease
__ Recent Steroid Use
__ Obesity
__ Diabetes Type I
__ Diabetes Type II
__ Other __________

**Pediatrics**: __ Normal
__ Recent URI/Illness
__ Developmental Delay
__ Prematurity
__ Congenital Anomaly
__ Other ____________

**Current Medications**

Medication: ______________________________ Dosage: ___________ Frequency: __________
Medication: ______________________________ Dosage: ___________ Frequency: __________
Medication: ______________________________ Dosage: ___________ Frequency: __________

**Allergies/RXN**
Medication/Seasonal/Foods
___________________________________
___________________________________
___________________________________

**Surgical Hx:** ______________________________________________________________________________

**Most recent Illness:** _______________________________________________Date of illness: _____________

**General Appearance:** ______________________________________________________________________

**HEENT**: __ PERRLA __ EOMI __ No Lymphadenopathy __ No JVD __ O/P MNL Thyroid Abnormal _____________

**Cardiovascular**: __ RRR S1S2 __S3 __S4 Abnormal _____________________________________________

**Pulmonary**: __ Lungs CTA B/L Abnormal _____________________________________________________

**GI**: __ Abd Benign-Normoactive BS __ No Hepatosplenomegaly Abnormal ____________________________

**Extremities**: __ No Clubbing __ No Cyanosis __ No Edema Abnormal _________________________________

**Musculoskeletal**: __ NML Muscle Tone __ NML Strength Abnormal ________________________________

**Neurological**: __ CN II-XII __ DTR Intact and equal bilaterally __ NML Mental Status Abnormal___________________
___________

## I certify I have completed the patient's history and physical.
## I clear this patient for General Anesthesia.

**Signature:** ________________________________ **Date:** ______________________

**Doctor Name:** ________________________________ **Phone #:** ______________ **Fax#:** _____________

**Office Name:** ________________________________