Salida Surgery Center
Dental Group

5712 Pirrone Road
Salida, CA 95368
Telephone 209-543-9299
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PRE-OPERATIVE PHYSICAL EXAMINATION

Dear Doctor: Today's Date: ___________________

We are referring patient: ____ Date of Birth: _____________
for a pre-operative complete History & Physical exam. Please complete this H&P form and add any additional labs you feel are needed. Our plan is for Complete Oral & Dental Rehabilitation under General Anesthesia in our facility.

Physical Exam: Age_________ Ht_________ Wt_________ Allergies____________________

Vitals: Temp __________ B/P__________ P__________ RR __________ Sats_____________

			DX:
General Appearance: --------	Normal/Abnormal		
Eyes: --------------------------	Normal/Abnormal		
Nose: -------------------------	Normal/Abnormal		
Pharynx: ---------------------	Normal/Abnormal		
Tonsils: --------------	Enlarged 1+ 2+ 3+		
Lymph Nodes: --------------	Normal/Abnormal		
Neck: -------------------------	Normal/Abnormal		
Heart: ------------------------	Normal/Abnormal		
Chest: ------------------------	Normal/Abnormal		
Lungs: -----------------------	Normal/Abnormal		
Abdomen: -------------------	Normal/Abnormal		
Extremities: -----------------	Normal/Abnormal		
Skin: -------------------------	Normal/Abnormal		
Neuro: -----------------------	Normal/Abnormal		

Narrative:____
____

Complaints/problems:____
____

Recommendations:____
____

Current Medications:____
____

Labs: None / Pending:____

By signing this Pre-Operative history & physical form, I attest that I am a licensed physician practicing in the State of California and full admitting privileges at ____,
Hospital Name
a local hospital.

Date: ____________________ Physician Name: ____