



Robert Graper, M.D. F.A.C.S.

History and Physical

Today's Date: _____ Name: _____ Age: _____

Anticipated type of procedure: _____

All of the following questions are to be completed by the patient, parent or guardian by checking YES or NO. If you check YES, please explain in the space provided.

	YES	NO		YES	NO
Do you have at present:			Were you born with any nervous system abnormalities?		
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any of the following:		
Asthma (as an adult)	<input type="checkbox"/>	<input type="checkbox"/>	Brain disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Spinal cord disease	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Nerve disease (MS, polio, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
How much? _____			Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Have you had the following:			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
If so, have you been told to take antibiotics prior to dental work?			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contacts lens?	<input type="checkbox"/>	<input type="checkbox"/>
Skipped heart beats	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a problem with stomach, bowel or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	If so, what: _____		
Hardening of the arteries	<input type="checkbox"/>	<input type="checkbox"/>	Pertains to females:		
Heart failure or attack	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever seen a cardiologist for any of the above problems?	<input type="checkbox"/>	<input type="checkbox"/>	Are you planning pregnancy preoperatively?	<input type="checkbox"/>	<input type="checkbox"/>
If so, who _____			Have you breast fed in the past three months?	<input type="checkbox"/>	<input type="checkbox"/>
What city? _____			Do you have:		
Do you have sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	Bridges	<input type="checkbox"/>	<input type="checkbox"/>
Other disease of blood cells	<input type="checkbox"/>	<input type="checkbox"/>	Crowns or dentures	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal blood clotting	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Have you had:			Problem opening mouth wide	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Problem in turning head	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Do any diseases run in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had:			What? _____		
Kidney infections (frequently)	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>			

Please further explain anything you checked YES or inform us of any medical problem not indicated on the checklist: _____

Previous operations and approximate dates: _____



Robert Graper, M.D. F.A.C.S.

Did you have: Bleeding blood clot, Infection, Nausea or vomiting. YES/NO checkboxes.

Anesthetic History: Allergy to drug used in dental work or surgery?, Any blood relative with serious allergy to anesthesia drug? YES/NO checkboxes.

Date of last general anesthetic, If you checked YES to any of the above questions, please explain:

Allergies (if non, please write "NONE") Drug name, Reaction

What is your Height, Weight

Please list all present medications and reasons for taking them. If none, write 'NONE'. Especially important are cortisone, hormone, birth control pills, aspirin or aspirin-type drugs, tranquilizers, sedatives or anti-depressants, blood thinners or anticoagulants, heart medications, diuretics.

Name of drug, Reason prescribed. Multiple lines for listing medications.

Do you faint easily? Do you bruise easily? Yes/No checkboxes.

Have you had a complete medical physical in the past 12 months? Have you had an electrocardiogram in the past 12 months? Yes/No checkboxes.

Who is your medical doctor? City?

Please sign: (patient signature)

(Please do not write below this line...Physician or Nursing Staff will complete this portion)

Physical Findings

Pulse, Blood Pressure, Occupation

Heart, Lungs, Bra size

Sno eye test, Pregnancy: Para, Gravida

Anesthesia preoperative evaluation:

Date:

Comments:

I have reviewed the above information and consider this patient to be a suitable candidate for surgery processes pending lab and medical clearance as required.