Dr. Phu-My Nguyen
109-200 Windflower Gate
Woodbridge, ON L4L 9L3
Tel: (905) 264-1KID (1543)
Fax: (905) 264-1536

PRE-OPERATIVE MEDICAL HISTORY

PATIENT NAME: _____
D.O.B.: _____
DATE OF EXAM: _____

INSTRUCTIONS: TO BE COMPLETED BY FAMILY PHYSICIAN WITHIN TWO WEEKS PRIOR TO SURGERY DATE.

BRING THIS FORM TO THE DENTAL OFFICE THE DAY OF SURGERY.

RELEVANT HISTORY (HOSPITALIZATIONS: ILLNESS, SURGERY)

_____

A. PAST HEALTH: _____

B: CONDITION REQUIRING SURGERY: _____

C: MEDICATIONS: _____ D: ALLERGIES: _____

E: ASA CLASSIFICATION: _____

PHYSICAL EXAMINATION

VITAL SIGNS

TEMPERATURE: _____^{O}C (ORAL/AX./RECTAL) WEIGHT: _____kg

BLOOD PRESSURE: _____ PULSE: _____

RESPIRATORY: _____

CARDIAC: _____

CIRCULATORY: _____

HEPATIC: _____

RENAL: _____

NEUROLOGICAL: _____

OTHER: _____

PROVISIONAL MEDICAL DIAGNOSIS: _____

COMPLETED BY:
PHYSICIAN'S NAME: _____ TELEPHONE # _____
ADDRESS: _____
_____
_____

_____ _____
SIGNATURE DATE