SAFE SLEEP
ANESTHESIA PARTNERS

History & Physical

Patient's Name:_____DOB: ____/____/____ Date of Treatment____/____/____

Physician:_____Physician's Phone:_____

History: (-) if negative (+) if positive *(If positive, please explain below)*

Allergies_____
Asthma_____
Pulmonary Disease_____
Diabetes_____
Heart Murmur_____
Heart Disease_____
Other Conditions_____
Immunizations up to date? Yes_____ No _____
Current Medications? Yes_____ No _____
List dose and schedule:_____

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_____

Physical Examination:

BP:___/____ Pulse: _____ Resp. Rate: _____ Temp: _____ Height: _____ Weight: _____

(-) if negative/normal (+) *(if abnormal, please explain below)*

Mental Status_____
Abdomen_____
Eyes_____
Ears_____
Nose_____
Throat_____
Dentition_____
Extremities_____
Chest_____
Heart_____
Lungs_____
Skin_____
Neck_____
Back_____
Neurological_____

Please explain any abnormalities:_____

Summary of Findings:_____

Comments or recommendations prior to surgery:_____

Physician Name (please print)**:**_____

Signature:_____**Date:**_____