SLEEPY TOOTH DENTAL

DR. JACOB EISDORFER
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MEDICAL CONSULT

This form is to be filled out by patient's physician as close to the scheduled treatment day as possible. Please comment on current systemic health, past medical history, and whether patient is medically optimized to undergo general anesthesia. Please advise if any workup or consultation is required prior to treatment. **Please fax to (347)-778-5112 and have the patient bring in original copy.**

NAME:_____ DOB: _____ WT: _____ lbs/kg HT:_____

BP:_____/_____ PULSE:_____ TEMP:_____ RR:_____ BMI:_____

MEDICATIONS	PREVIOUS SURGERIES	ALLERGIES

CV: _____

HTN	CAD	CHF	VALVULAR DISEASE	ARRHYTHMIAS	PPD/AICD	HYPERLIPIDEMIA

PULMONARY:_____

ASTHMA	COPD	URI	PRODUCTIVE COUGH	SLEEP APNEA	O2 DEPENDENT	SEASONAL ALLERGIES

RENAL/ENDOCRINE:_____

DM 1 / 2	RENAL INSUFF	THYROID	PREGNANT	OBESE

GI:_____

GERD	HERNIA	CIRRHOSIS	N/V

NEURO/SKELETAL:_____

CVA	SYNCOPE	SEIZURE	SPECIAL NEEDS	PSYCH HX	ARTHRITIS	MUSCULAR DYSTROPHY/DYSTONIA

HEMATOLOGIC:_____

ANEMIA	COAGULOPATHY	CANCER	CHEMO/ RADIO	OBGYN

METABOLIC:_____
_____
_____

INFECTIOUS DISEASE:_____

COMMENTS (FURTHER DETAILS, ACUTE EPISODES IN MED HX, FAMILY HX OF ANESTHESIA COMPLICATIONS, MEDICALLY OPTIMIZED?, ETC…)	LAB WORK / RADIOLOGICAL / STUDIES

PHYSICIAN NAME:_____ DATE:_____/_____/_____

PHYSICIAN SIGNATURE:_____ CONTACT PHONE:_____