PRE-ANAESTHETIC RECORD
PHYSICIAN'S ASSESSMENT

Dear Doctor,

Your patient is scheduled for dental treatment under general anaesthesia. Please complete this history and physical examination form, and return it to our office by _____. If you have any questions, please call. Thank you for your assistance.

Patient's Name _____ Date of Birth _____ Phone _____

Address _____

City/Province _____ Postal Code _____

Planned Dental Treatment _____

_____

ALLERGIES	
MEDICATION	
FUNCTIONAL INQUIRY	Cardiac
	Respiratory
	Other
PAST ILLNESS	Anaesthesia Experience
	Other
FAMILY HISTORY	Anaesthesia Problems
	Other
PHYSICAL EXAMINATION	General Appearance
	B/P _____ P. _____ R. _____ Wt. _____ Ht. _____
	Head, Neck and Intraoral
	Heart
	Lungs
	Abdomen
	Skeletal
	CNS
	Laboratory Tests
ASA CLASSIFICATION	I II III IV V E

Date _____ Physician's Signature _____