HISTORY AND PHYSICAL PRE-OP FORM

To be completed by the child's primary care physician

NAME: DOB:

DIAGNOSIS: **EARLY CHILDHOOD CARIES**

PRESENT ILLNESS: **PRE-OP ASSESSMENT-OUTPATIENT**

ALLERGIES:____

MEDICATIONS:____
____

SURGERY:____
____

FAMILY HISTORY NEGATIVE EXCEPT:____

PHYSICAL EXAM:

HEIGHT: WEIGHT: TEMP: PULSE: RESP: B/P:____/____

	NORMAL	**ABNORMAL**	**NA**	**ABNORMAL FINDINGS**
HEENT				
BREASTS				
C/V SYSTEM				
LUNGS				
ABDOMEN				
GENITALIA				
M-S SYSTEM				
NEUROLOGIC				
PSYCHO-SOCIAL				

NORMAL=WITHIN NORMAL LIMITS **ANY"ABNORMAL" WILL BE EXPLAINED**

PHYSICIAN
SIGNATURE__________________________________DATE:_____________TIME________

PLEASE FAX FORM TO: 903-891-9339 Attn: SABRINA