BELLEVILLE SLEEP DENTISTRY
Dr. Michael Chow Board Certified Dentist-Anaesthesiologist
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ATTENTION: MUST BE COMPLETED BY A PHYSICIAN

Medical History and Physical Review

Patient Name:	***Instructions to patient or guardian:***
Date of Birth:	1. **Please fill out the information on the left**
Guardian Name: (if applicable):	2. **Please contact your physician's office and ask to have this form completed. Your physician might require that you schedule an appointment in order to accurately complete the paperwork.**
Relationship to patient:	3. **This form must be returned to our office at least 2 business days prior to scheduling an appointment. We will contact you once Dr. Chow has evaluated the medical documentation and made a decision regarding patient suitability for in-office sedation.**
Address:	
Telephone Number Day:	
Evening:	
Dentist Name:	

Dear Doctor,
Your patient is scheduled for dental treatment **with in-office sedation or general anaesthesia** on **to be determined** .
Please complete all areas of this history and physical examination form, incomplete forms will delay treatment for the patient. **For patients with a cardiac history or over the age of 50,** please send us (if available) the following lab work: hemoglobin, electrolytes, creatinine and ECG. Any other information or commentary is appreciated.
Please contact our office if we can be of any assistance. **I greatly appreciate your time and effort.**

Allergies	**Medications**

Immunization Status in accordance with Ontario's Routine Immunization Schedule ☐ **yes** ☐ **no**

Functional Inquiry:	**Cardiac**	**Respiratory**	**Other**

Past Illnesses, Previous surgeries — **Other**	**Family History Anaesthesia Problems** — **Other**

Physical Exam (*Please complete all areas*)

BP	**Head and Neck**	**Physician Signature/Stamp:**
Pulse	**Heart**	
Rhythm	**Lungs**	
CNS	**Abdomen: GI Liver/Kidneys**	
Height	**Musculoskeletal**	**Date:**
Weight (kg)		

Patient suitable for in-office general anesthesia: ☐ **yes** ☐ **no** ☐ **further assessment required**
Additional Comments:

PLEASE ASK YOUR FAMILY PHYSICIAN TO FAX THE COMPLETED FORM TO 613-962-7778.
COMPLETED FORMS MAY ALSO BE RETURNED TO OUR OFFICE IN PERSON, BY MAIL OR EMAIL.