REVIEW OF SYSTEMS (CONTINUED)	
Neurological: ❑ Syncope ❑ Convulsions ❑ Dizziness ❑ Dysarthria ❑ Dysphasia ❑ Tremor ❑ Weakness ❑ Pain ❑ Numbness ❑ Increased clumsiness ❑ Memory loss ❑ Increased confusion	❑ No abnormalities noted
Psychiatric: ❑ Behavioral changes ❑ Prolonged crying ❑ Loss of desire to socialize ❑ Change in sleeping patterns ❑ Difficulty thinking ❑ Fears ❑ Hallucinations ❑ Previous emotional illness or treatment	❑ No abnormalities noted
Lymphatic: ❑ Swelling ❑ Pain	❑ No abnormalities noted
Integumentary: ❑ Rash ❑ Itching ❑ Bruising ❑ Lesions	❑ No abnormalities noted
Immune:	❑ No abnormalities noted

PHYSICAL EXAMINATION	
Integumentary Exam:	❑ No abnormalities noted
Lymphatics:	❑ No abnormalities noted
HEENT:	❑ No abnormalities noted
Neck:	❑ No abnormalities noted
Breasts:	❑ No abnormalities noted
Respiratory System:	❑ No abnormalities noted
Cardiovascular: ❑ Rhythm ❑ Murmurs ❑ Heart sounds ❑ Edema ❑ Bruits (carotid/femoral) ❑ Peripheral abdominal pulses	❑ No abnormalities noted
Gastrointestinal: ❑ Distention ❑ Ascites ❑ Bowel sounds ❑ Rectal Masses: ❑ Liver ❑ Spleen	❑ No abnormalities noted
Genitourinary:	❑ No abnormalities noted
Musculoskeletal/Extremities:	❑ No abnormalities noted
Neurological:	❑ No abnormalities noted

IMPRESSIONS & PLAN

Physician signature

Physician name (**PRINT**)

Date

Time

ALL FOR KIDS™
DENTAL

Dear_____:

_____ (DOB: _____) is scheduled to have a History and Physical with your office on_____ for clearance prior to surgery.

We have scheduled this patient for full mouth dental rehabilitation at Newton Medical Center. Prior to the procedure, the patient will need a History and Physical from you stating he/she is fine to have this procedure completed. Thank you for providing this service. Please fax your History and Physical to *All for Kids Dental Group*. Also, please give the patient a copy of the H&P for them to bring with them on the day of surgery. The patient will receive his/her appointment/phone interview on or before the scheduled day of surgery after the History and Physical is completed. However, they do need your History and Physical before the surgery can proceed. Please call the nurses at *All for Kids Dental Group* if you have any questions at 770-784-7099. I have enclosed the History and Physical form that needs to be filled out and faxed back.

Thank you for your help.

The fax number for All for Kids Dental Group is 770-784-5283.

******PLEASE STATE THAT PATIENT IS "CLEARED FOR DENTAL SURGERY" ON PLAN LINE*******

Sincerely,

Adrian Miller, DDS
Pedodontist
O:770-784-7099
F:770-784-5283

Piedmont HEALTHCARE

HISTORY & PHYSICAL RECORD

Patient Label

Date of Admission	Chief Complaint
Vital Signs Pulse:_____ Respiration:_____ BP:_____ Temp:_____	

History of Present Illness

PAST MEDICAL/SURGICAL HISTORIES & CURRENT MEDICATIONS

Surgeries/Date	Medical Problems/Conditions	Allergies	Medications/OTC Drugs/Vitamins/Herbs

FAMILY HISTORY

Complaint/Problem	Mother	Father	Sister	Brother	Grandparents
Alzheimer's					
Asthma					
Cancer					
Diabetes					
Heart problems					
Stroke					

PERSONAL/SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced		Children: ❑ Yes ❑ No Number:	
Tobacco Use: ❑ Yes ❑ No	Frequency of Use:	Employment Status: ❑ Employed ❑ Unemployed ❑ Retired	
Alcohol Use: ❑ Yes ❑ No	Frequency of Use:	Are you depressed? ❑ Yes ❑ No Comments:	
Recreational Drugs: ❑ Yes ❑ No	Frequency of Use:		

Advance Directive (AD): ❑ No interest in an AD ❑ Provided a copy today ❑ No AD (or no copy with me today), but my wishes are:

REVIEW OF SYSTEMS

System	Written Comments Concerning Abnormal Findings
Constitutional: ❑ Fever ❑ Chills ❑ Abnormal weight loss ❑ Abnormal weight gain ❑ Fatigue	❑ No abnormalities noted
Respiratory: ❑ Cough ❑ Wheezing ❑ Dyspnea ❑ Hemoptysis ❑ Increased sputum production ❑ Painful to breathe ❑ Night sweats ❑ Infections	❑ No abnormalities noted
Cardiovascular: ❑ Chest pain ❑ Palpitations ❑ Syncope ❑ Calf pain ❑ Rapid heartbeat ❑ Easily fatigued ❑ Edema ❑ Elevated BP ❑ Heart sounds/murmurs ❑ Heart disease	❑ No abnormalities noted
Gastrointestional/Digestive: ❑ Changes in appetite ❑ Pain ❑ Dyspepsia ❑ Acid indigestion ❑ Eructation ❑ Distention ❑ Nausea ❑ Vomiting ❑ Hematemesis ❑ Hernias ❑ Jaundice ❑ Rectal pain ❑ Change in bowel habits ❑ Blood in stool ❑ Hemorrhoids	❑ No abnormalities noted
Urinary/Excretory: ❑ Dysuria ❑ Frequency ❑ Urgency ❑ Polyuria ❑ Oliguria ❑ Retention ❑ Dribbling ❑ Hesitancy ❑ Stones ❑ Infection	❑ No abnormalities noted
Genital/Reproductive: ❑ Pain ❑ Genital Lesions ❑ Venereal disease ❑ Vaginal discharge ❑ Urethral discharge ❑ Testicular pain/swelling LMP:_____ ❑ N/A Number of live births ( ), Stillborns ( ), Abortions ( )	❑ No abnormalities noted
Endocrine: ❑ Abnormal weight change ❑ Easily fatigued ❑ Diabetes ❑ Polyuria ❑ Polydipsia ❑ Sensitivity to heat or cold ❑ Abnormal sweating	❑ No abnormalities noted
Musculoskeletal: ❑ Injury ❑ Pain ❑ Tenderness ❑ ROM limitations ❑ Swelling or joint stiffness	❑ No abnormalities noted

Physician signature | Physician name (**PRINT**) | Date | Time