

Surgical Clearance Checklist

Name _____ Date _____



History of Medical Problems

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Kind _____)
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Surgery	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ HIV or Exposure
<input type="checkbox"/>	<input type="checkbox"/>	Palpitation/Irregular Heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Blood Clots
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Stroke (When)_____	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Bypass Surgery (When)_____	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement Surgery

A. Do you smoke? Yes No How much? _____

B. (Women) Are you pregnant or nursing? Yes No

C. Do you bleed easily? Yes No

D. **List Medication**
Allergies

E. List any other condition or disease we should know about. _____

F. Have you ever had a blood transfusion? Yes No When? _____

G. Any previous reactions to local anesthesia? Yes No

H. Have you been advised to take antibiotics before dental procedures? Yes No

I. How many flights of stairs can you climb without stopping? 0-1 2-3 4 or more

Circle any of the following supplements or medications that you take:

ASPIRIN Vitamin E Ginko Biloba Ginseng Ephedra Garlic Feverfew

Current Medications

I consent to having photographs taken and agree that these images will be used only to document my care, for teaching, demonstrations of the surgery or publication in professional journals.

Signature _____ Reviewed _____