HISTORY AND PHYSICAL
(Short Stay - Less than 48 hours)

Patient Name: ________________________

Patient DOB: _____-_____-_____

MRN: ___________________________

Return completed form to Swiatowicz Dental Associates 302-200-3735 or 302-476-8188 or DEtoothDR@gmail.com.

Instructions:

To be completed by a physician NO MORE THAN 30 days prior to surgical date. Detail problems in associated areas.

HISTORY	
Chief Complaint	
History of Present Illness	
Past Medical and Surgical History	
Allergies	
Medications	
Psychological Assessment	

PHYSICAL EXAMINATION			
Pulse:	Blood pressure:	Respiratory rate:	Pain level(0-10):

General	
Head and Neck	
Heart and Lungs	
Abdomen	
Rectal and/or Pelvic Examination	
Extremities	
Neurological Examination	
Other Pertinent Physical Findings	
Diagnosis/ Impression	
Initial Plan of Care	

______________________	______________________	___/___/___	____________
Physician Signature/Title	Printed Name or ID #	Date	Time