Michael D. Vaughan, D.D.S.

Dental Sedation Medical Clearance Form

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PATIENT INFORMATION

*Patient name:	*Date of birth:

MEDICAL HISTORY

☐ Seizures	☐ Anemia	☐ Acid Reflux
☐ Hypertension	☐ Autism	☐ Hemophilia
☐ Cardiac Murmurs	☐ Diabetes Type I	☐ Bleeding Disorders
☐ Cardiac Anomalies	☐ Diabetes Type II	☐ Cleft Lip/Cleft Palate
☐ Asthma	☐ Thyroid Problems	☐ Cerebral Palsy
☐ Airway/Trachea Anomaly	☐ Liver Disease	☐ Intellectual Disability
☐ Hepatitis	☐ Kidney Disease	☐ ADD/ADHD

*List any other medical history:
*List all current medications (name, dose and frequency):
List all allergies and reactions **(including medications, foods and latex)**:
Past surgeries and dates:

PHYSICAL EXAM

System	Findings	Vitals	Values
HEENT:		**Height:**	
Cardiac:		**Weight:**	
Lungs:		**BP:**	
Abdomen:		**HR:**	
Extremities		**SaO2:**	
Neuro/Psych:		**Temp:**	
Is Antibiotic Prophylaxis Recommended: ☐ Yes or ☐ No			
Is this patient medically clear for sedation for dental procedure? ☐ Yes or ☐ No			

_____ _____ _____

Physician Name (print) Physician Signature Date