

Patient Information for Deep Sedation/General Anesthesia

Title: Mr. Mrs. Ms. Miss Dr.	
First Name	Weight
Last Name	Height
Date of Birth//	
Day Month Year	BP: / Pulse: bpm
Home Phone	
Business Phone	
Cell Phone	
erson responsible for taking you home after treatment:	Person to contact in case of emergency:
ame	Same: Yes or No
hone Number	Name
elationship	Phone Number
	Relationship
Family Physician: Dr	
Phone	

As per office protocol, the following information will be assessed by one of the Anesthetists (MD) who provide anesthetics in our office.

Pre-Anesthetic H	ealth Questionnaire	Yes	No
Cardiovascular			
Do you have or	Anemia (including sickle cell)		
have you had:	Bleeding disorder or excessive bleeding after dental/surgical procedures		
	Hypertension		
	Arrhythmia. If yes, what type?		
	Coronary artery disease (angina/heart attack)		
	If yes, have you had stents or a bypass? When?		
	If yes, do you still have angina? How often?		
	Heart failure		
	Swollen ankles		
	Valvular disease or heart murmur. Please specify		
	Pacemaker. If yes, when was it put in?Why?When was it last checked?		
	Peripheral vascular disease		
	Congenital heart disease		
Respiratory			
Do you have or	Asthma. If yes, have you been hospitalized for it?		
have you had:	COPD (emphysema or chronic bronchitis). If yes, have you been hospitalized for it?		
are year.aar	Shortness of breath after climbing 2 flights of stairs or walking 2 blocks?		
	Shortness of breath at rest		
	Tuberculosis		
	Smoking history. If yes, how many per day? For how many years? When		
	did you quit?		
	Do you have obstructive sleep apnea (OSA)? If yes, is it mild / moderate / severe)? Was a		
	CPAP machine recommended? Do you use it?		
	Do you snore loudly enough to be heard through closed doors? Y / N		
	Do you ever feel tired during the day? Y / N		
	Has anyone observed you to stop breathing while sleeping? Y / N		
	Do you have or are you being treated for high blood pressure? Y / N		
	Is your BMI (weight in kg/(height in m) ²) >35? Y / N		
	Are you over 50? Y / N		
	Is your neck circumference >40cm? Y / N		
	Are you male? Y / N		
	(If 3 or more of these 8 answers are yes, you are at high risk for OSA.)		
Gastrointestinal	(i) 5 of more of these of answers are yes, you are at might risk for ost ii)	<u> </u>	
Do you have or	Heartburn/acid reflux. If yes, is it controlled with medication?		
have you had:	Ulcers		
nave you nau.	Liver disease		
	Hepatitis		
	Jaundice		
	More than 1 drink a day?		
	Wore than I drink a day:		
Urological			
Do you have or	Kidney dysfunction		
have you had:	Kidney stones		
nave you nau.	Nulley Stolles	Voc	No
Endocrine		Yes	No
	Diabates If you are you taking insuling		
Do you have or	Diabetes. If yes, are you taking insulin? Do you have any complications such as		
have you had:	trouble with your eyes, kidneys, or nerves?	VEC	NO
	Thursid disease	YES	NO
	Thyroid disease		

Musculoskeletal			
Do you have or	Osteoporosis		
have you had:	Lupus		
	Arthritis. If it is rheumatoid arthritis, is your neck stable?		
	Chronic pain		
	Muscle disorders (e.g. muscular dystrophy)		
	Trouble opening your mouth fully		
	Problems moving your neck freely		
Neurological			
Do you have or	Stroke or TIA. If yes, when was it and do you have any residual weakness/damage?		
have you had:			
	Seizures. If yes, when was your last one? How often do you get them?		
	What happens when you have one?		
	Dementia		
	Parkinson's disease		
	Multiple sclerosis		
Allergies, Medica	·		
_	o any medications? Please list which drugs and what reaction you have.		
, 5	, ,		
Are vou allergic to	o latex? If yes, what reaction do you have?		
	'AIDS or other problems with your immune system?		
	rednisone or another steroid by mouth in the last 6 months?		
	ny recreational drugs in the last month (e.g. marijuana, LSD, cocaine, oxycontin)? If yes,		
•	nat and how frequently		
produce specify in	.acananan nagaana,		
Have you/your bl	ood relatives had any troubles with anesthesia (e.g. Nausea and vomiting, malignant		
	eudocholinesterase deficiency). If yes, please indicate who has had what reaction.		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Do vou have any	medical problems not listed above? If yes, please describe below:	II.	
, , , , , , , , , , , , , , , , , , , ,	,, p		
Do you have any	caps/veneers/bridges/dentures/loose teeth? Please specify what and where.		
,			
Please list any pro	evious operations you have had:		
, ,			
Please list your cu	urrent medications (including puffers, herbal and over the counter medications) and indicate	what y	ou
are taking each fo		•	
Patient Signature	Date		