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 _____

Person responsible for taking you home after treatment:

Name _____

Phone Number _____

Relationship _____

Person to contact in case of emergency:

Same: Yes or No

Name _____

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 Health Questionnaire		Yes	No
Cardiovascular			
Do you have or have you had:	Anemia (including sickle cell)		
	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 have you had:	Asthma. If yes, have you been hospitalized for it? _____		
	COPD (emphysema or chronic bronchitis). If yes, have you been hospitalized for it?_____		
	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			
Do you have or have you had:	Heartburn/acid reflux. If yes, is it controlled with medication? _____		
	Ulcers		
	Liver disease		
	Hepatitis		
	Jaundice		
	More than 1 drink a day?		
Urological			
Do you have or have you had:	Kidney dysfunction		
	Kidney stones		
		Yes	No
Endocrine			
Do you have or have you had:	Diabetes. If yes, are you taking insulin? _____ Do you have any complications such as trouble with your eyes, kidneys, or nerves? _____		
		YES	NO
	Thyroid disease		

Musculoskeletal			
Do you have or have you had:	Osteoporosis		
	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 have you had:	Stroke or TIA. If yes, when was it and do you have any residual weakness/damage? _____		
	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, Medications and Other			
Are you allergic to any medications? Please list which drugs and what reaction you have.			
Are you allergic to latex? If yes, what reaction do you have?_____			
Do you have HIV/AIDS or other problems with your immune system? _____			
Have you taken prednisone or another steroid by mouth in the last 6 months?			
Have you used any recreational drugs in the last month (e.g. marijuana, LSD, cocaine, oxycontin)? If yes, please specify what and how frequently _____			
Have you/your blood relatives had any troubles with anesthesia (e.g. Nausea and vomiting, malignant hyperthermia, pseudocholinesterase deficiency). If yes, please indicate who has had what reaction. _____			
Do you have any medical problems not listed above? If yes, please describe below:			
Do you have any caps/veneers/bridges/dentures/loose teeth? Please specify what and where.			
Please list any previous operations you have had:			
Please list your current medications (including puffers, herbal and over the counter medications) and indicate what you are taking each for:			

Patient Signature_____ Date _____