PreAnesthesia Medical Questionnaire

Patient Data

Date ____________

Patient Name ________________________________ DOB __________ AGE ____ Weight _____ lbs Height ___' ___"

Cell ______________________________ Email ______________________________

Dental Office / Dentist ______________________________ Date of Procedure ______________

Procedure to be done ______________________________

General Medical Section

List medications or use any inhalers? Taking Steroids or antibiotics for any reason? If so list below

____

____

____

Allergic to any medications / Latex / other - Please describe reaction

____

Prior surgeries? If yes, please list ; Also state the approximate time of surgeries if in the past 1 year:

____

____

Any problems with surgery or anesthesia? (Difficult Intubation, Malignant Hyperthermia) Elaborate if yes:

____

____

Any family history of problems with anesthesia ? (Malignant Hyperthermia , other)

____

Do you Smoke? □ Cigarettes □ E-cigs □ Marijuana

Amount ,ie ½ Pack per day (PPD) ______________________________

Consume Alcohol □ Yes □ No □ Daily Number Drinks Per Week ______________

Other Recreational Drugs ______________________________

Are you able to go up 2 flights of stairs or walk 2 blocks without Chest Pain and or Shortness of Breath ?

□ Yes □ No , Explain if you can not ______________________________

Any Physical Limitations ______________________________

Any recent illness or hospitalizations within the last 6 months (Colds, Pneumonias, Stroke, other ; Please state start date and if receiving any treatments)

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Specific Systems

Pulmonary / Respiratory Conditions (Lungs) :

□ Obstructive Sleep Apnea . if yes, do you use CPAP / BIPAP? □ Yes □ No

□ Asthma □ COPD □ Chronic Bronchitis □ Emphysema □ Pulmonary Embolism

□ Other ______________________________

ENT - Ear Nose Throat

□ Seasonal Allergies □ Sjögren syndrome □ Chronic Vertigo □ Meniere's disease

Other ______________________________

Neurologic :

□ TIA or Mini-stroke □ Stroke If yes Year__________ Any Impairments due to stroke ______________

□ Seizure Disorder ______________________ □ Brain Aneurysm □ Peripheral Neuropathy

□ Alzheimers Disease □ Parkinsons Disease □ Myasthenia Gravis □ MS

□ Other Neurological ______________________________

Cardiovascular Conditions: ◻ High Blood Pressure ◻ Congestive Heart Failure / swelling of feet/ankles
◻ Peripheral Vascular Disease ◻ Irregular Heart Rhythm ◻ Atrial Fibrillation ◻ Pacemaker / Defibrillator
◻ Heart Murmur ◻ High Cholesterol
◻ Heart Disease (Coronary Artery Disease) ◻ Heart Attack , if yes please answer the following questions:
Year of Heart Attack __________
What was done as Treatment? ◻ Bypass Surgery ◻ Stents ◻ Balloon Angioplasty ◻ Treated with Medications
How is the heart now? ____
Chest Pain at Rest? ◻ Yes ◻ No Chest pain during activity ◻ Yes ◻ No
Last Cardiologist Visit and Recommendation ________________________________
Last Stress Test Year ________ Result ___________ Last Echocardiogram Year if Known ______________
Other Cardiovascular Conditions ____

Gastrointestinal ◻ Acid Reflux ◻ Gastritis ◻ Ulcers ◻ Irritable Bowel Syndrome ◻ Ulcerative Colitis ◻ Crohn's disease
◻ Hepatitis , type ____________ ; Other Gastrointestinal ______________________________

Developmental Disorders ◻ Cerebral Palsy ◻ Down Syndrome ◻ Autism ; Other ______________________

Psychiatric ◻ Anxiety ◻ ADHD ◻ Psychosis ◻ Depression ◻ Bipolar ◻ PTSD ; Other ____________________

Hematologic Conditions:
◻ History of Abnormal Bleeding ◻ Yes ◻ No Explain ______________________________
◻ History Excessive Blood Clotting ◻ Yes ◻ No Explain______________________________
◻ G6PD Deficiency ◻ Sickle Cell Disease (◻ Trait) ◻ Anemia
List Other hematologic ____

Urological (**Kidney/ Bladder/ Prostate Conditions)**
◻ BPH ◻ Problems with Urination, elaborate__________________________________
◻ Kidney Stones ◻ Kidney Failure
List other Urological ____

Musculoskeletal ◻ Rheumatoid Arthritis ◻ Chronic Back Pain ◻ History of Neck Spine surgery or fusion
List Other Musculoskeletal ____

Endocrine ◻ Diabetes ◻ Diabetic Neuropathy ◻ Hypothyroidism ◻ Hyperthyroidism
List other ____

Dermatologic ◻ Eczema ◻ Psoriasis
List other Dermatological ____

Immunodeficiency ; Please Elaborate ____

◻ HIV ◻ Systemic lupus erythematosus ◻ Chronic Pain of any kind (Elaborate) ______________________

◻ Malignancy ; if checked elaborate ____

◻ History of Head or Neck Radiation

◻ Other, Please list anything not listed above

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Signature ______________________________ **Date** ________________________

Please inform us of any changes in health **including colds before the day of the procedure. Please email us at info@SafeDentalSedation.com**