Dental Anesthesia Northwest, PLLC

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Surgeon/Dentist or Practice Name:
____

PATIENT INFORMATION / MEDICAL HISTORY

PLEASE PRINT IN BLACK INK

PATIENT INFORMATION

Date: ______________________ Cell Phone: __________________________________
Name: ____ Best Phone # to Contact: ________________________
Date of Birth: ______________ Gender: O Male O Female Height: ___________ Weight: __________________
Mailing Address: ____
Email: ____ Social Security Number: ________________________

GENERAL INFORMATION

Person Completing Form:	Relationship to patient:
Parent / Guardian:	Phone:
Primary Care Physician Name:	Phone:
Medical Specialist (type):	Phone:
Medical Specialist (type):	Phone:

Current Medications: (Please list all current medications including over-the-counter and herbal medications. Attach additional pages if necessary.)

Medication	Dosage	For the treatment of:

Allergic or Unusual Reactions

O Penicillin O Sulfa Drugs O Opiates / Codeine O Iodine
O Latex O Local Anesthetics O Aspirin O Metals______________________________
O Other Medications:____
O Other substances (foods, etc.) ____
Type of Reactions:

GENERAL MEDICAL INFORMATION

What is your general state of health? O Excellent O Good O Fair O Poor

Has there been any change in your general health in the past year? O Yes O No O Unsure
If yes, please explain: ____

Date you last visited your physician: ________________________ Reason __________________________________

GENERAL MEDICAL INFORMATION CONT…

Have you been in the hospital in the past five years for any reason? O Yes O No O Unsure
If yes, please explain: ____

Have you had surgery in the past five years? O Yes O No O Unsure
If yes, please explain: ____

Have you taken or used any steroids in the past year? O Yes O No O Unsure
If yes, what dose ________, and how frequent _____________, and for how long __________________?
If you have taken steroids in the last year but are no longer taking them, when was the last dose?________

Have you taken any blood thinners in the last year? O Yes O No O Unsure
If yes, when was your last dose? ____

Are you under the care of any of the following? (please circle)
Cardiologist, Pulmonologist, Endocrinologist, Hematologist, Oncologist, Neurologist, Pediatrician, Geneticist, None

Do you drink alcoholic beverages? O Yes O No O Unsure
If yes, how much did you drink in the last 24 hours? ____
If yes, how much do you typically drink in a week?____

Do you use controlled substances (street or recreational drugs)? O Yes O No O Unsure
If yes, what types of substances do you use? ____
If yes, what and how much did you use in the last 24 hours? ______________________________________

Have you ever used tobacco (smoking, snuff, chew, E-cigs)? O Yes O No O Unsure
If yes, what_________________, and how much__________________, for how long _______________?
If no longer using tobacco, when did you stop? ____

ANESTHESIA HISTORY

Date of most recent sedation or anesthetic: ____
Type of procedure:___________________________ Location of procedure:___________________________

List of past surgeries: ____
____
____

Have you ever had or do you have any of the following:
Abnormal reactions to anesthesia? O Yes O No O Unsure ________________________________
Nausea and/or Vomiting O Yes O No O Unsure ____
Personal or family history of Malignant Hyperthermia? O Yes O No O Unsure _______________
Relatives with abnormal reactions to anesthesia? O Yes O No O Unsure____________________

Has sedation ever been used for dental care? O Yes O No O Unsure ________________________________
If yes, check all that apply: O Nitrous Oxide (laughing gas) O Oral sedation O IM (Intramuscular) O IV (Intravenous) O GA (General Anesthesia)

PAST MEDICAL HISTORY

Check the symptom(s) and illness(s) or condition(s) that you currently HAVE or have HAD:

Cardiovascular:

O Yes O No O Unsure .... Activities limited for any reason ____________
O Yes O No O Unsure .... Shortness of breath with exertion ____________
O Yes O No O Unsure .... Heart murmur ____________
O Yes O No O Unsure .... Mitral valve prolapse ____________
O Yes O No O Unsure .... Artificial heart valves ____________
O Yes O No O Unsure .... Pacemaker / ICD ____________
O Yes O No O Unsure .... Coronary artery disease ____________
O Yes O No O Unsure .... Angina (Chest pain) ____________
O Yes O No O Unsure .... Arrhythmias (Irregular heart beat) ____________
O Yes O No O Unsure .... Congestive heart failure ____________
O Yes O No O Unsure .... Heart attack ____________
O Yes O No O Unsure .... High blood pressure ____________
O Yes O No O Unsure .... Low blood pressure ____________
O Yes O No O Unsure .... Congenital heart defects ____________
O Yes O No O Unsure .... Shunt ____________
O Yes O No O Unsure .... Other ____________

Respiratory:

O Yes O No O Unsure .... Asthma ____________
O Yes O No O Unsure .... Bronchitis ____________
O Yes O No O Unsure .... Emphysema ____________
O Yes O No O Unsure .... Pneumonia ____________
O Yes O No O Unsure .... Tuberculosis (TB) or Positive TB test ____________ Date:____________
O Yes O No O Unsure .... Tracheomalacia ____________
O Yes O No O Unsure .... Croup ____________
O Yes O No O Unsure .... Sinus trouble ____________
O Yes O No O Unsure .... Sleep apnea - CPAP / BIPAP ? ____________
O Yes O No O Unsure .... Aspiration ____________
O Yes O No O Unsure .... Cystic Fibrosis ____________
O Yes O No O Unsure .... Other ____________

Metabolic / Hormonal:

O Yes O No O Unsure .... Diabetes: Type I or Type II ____________ Most Recent HbA1C ____________
O Yes O No O Unsure .... Thyroid problems ____________
O Yes O No O Unsure .... Adrenal Insufficiency ____________
O Yes O No O Unsure .... Other ____________

Gastrointestinal:

O Yes O No O Unsure .... Acid reflux / Heartburn ____________
O Yes O No O Unsure .... Hiatal hernia ____________
O Yes O No O Unsure .... Ulcer / Gastritis ____________
O Yes O No O Unsure .... Irritable bowel syndrome / Colitis ____________
O Yes O No O Unsure .... Eating disorder ____________
O Yes O No O Unsure .... Malnutrition ____________
O Yes O No O Unsure .... Feeding issues ____________
O Yes O No O Unsure .... Tube fed ____________
O Yes O No O Unsure .... Other ____________

Check the symptom(s) and illness(s) or condition(s) that you currently HAVE or have HAD:

Hematologic:

O Yes O No O Unsure .... Abnormal bleeding ____
O Yes O No O Unsure .... Anemia ____
O Yes O No O Unsure .... Blood Transfusion: ____ Date: ____
O Yes O No O Unsure .... Hemophilia ____
O Yes O No O Unsure .... Sickle Cell Anemia ____
O Yes O No O Unsure .... Other ____

Cancer / Neoplastic Disease:

O Yes O No O Unsure .... Cancer ____
O Yes O No O Unsure .... Leukemia / Lymphoma ____
O Yes O No O Unsure .... Chemotherapy ____
O Yes O No O Unsure .... Radiation Treatment ____
O Yes O No O Unsure .... Other ____

Major Organ Disease:

O Yes O No O Unsure .... Kidney disease ____
O Yes O No O Unsure .... Liver disease ____
O Yes O No O Unsure .... Spleen surgery ____
O Yes O No O Unsure .... Bladder disease ____
O Yes O No O Unsure .... Organ transplant ____
O Yes O No O Unsure .... Other ____

Neurologic:

O Yes O No O Unsure .... Epilepsy / Seizures ____
O Yes O No O Unsure .... Paralysis / Weakness ____
O Yes O No O Unsure .... Stroke____ Date ____
O Yes O No O Unsure .... Traumatic brain Injury:____ Date: ____ Details: ____
O Yes O No O Unsure .... Shunt____
O Yes O No O Unsure .... Other ____

Immune System Disorder:

O Yes O No O Unsure .... Autoimmune disease ____
O Yes O No O Unsure .... Multiple Sclerosis____
O Yes O No O Unsure .... Rheumatoid arthritis ____
O Yes O No O Unsure .... Lupus erythematosus (SLE) ____
O Yes O No O Unsure .... Sjogren's syndrome ____
O Yes O No O Unsure .... Other ____

Musculoskeletal Disorder:

O Yes O No O Unsure .... Muscular Dystrophy / Muscular disease or weakness____
O Yes O No O Unsure .... Neck trouble ____
O Yes O No O Unsure .... Back trouble ____
O Yes O No O Unsure .... TMJ or other jaw pain ____
O Yes O No O Unsure .... Spina Bifida ____
O Yes O No O Unsure .... Scoliosis ____
O Yes O No O Unsure .... Osteoporosis ____
O Yes O No O Unsure .... Osteoarthritis ____
O Yes O No O Unsure .... Artificial (prosthetic) joint ____
O Yes O No O Unsure .... Other ____

Check the symptom(s) and illness(s) or condition(s) that you currently HAVE or have HAD:

Genetic (Inherited) / Chromosomal Condition:

O Yes O No O Unsure .... Trisomy 21 (Down Syndrome) ____________________
O Yes O No O Unsure .... Other ____________________

Infectious Diseases:

O Yes O No O Unsure .... Rheumatic fever ____________________
O Yes O No O Unsure .... MRSA ____________________
O Yes O No O Unsure .... Sexually transmitted diseases ____________________
O Yes O No O Unsure .... Herpes ____________________
O Yes O No O Unsure .... Fungal infections ____________________
O Yes O No O Unsure .... Hepatitis ____________________
O Yes O No O Unsure .... HIV / AIDS ____________________
O Yes O No O Unsure .... Other ____________________

Behavioral Conditions:

O Yes O No O Unsure .... Psychiatric illness ____________________
O Yes O No O Unsure .... Dementia / Alzheimer's ____________________
O Yes O No O Unsure .... Autistic spectrum disorder ____________________
O Yes O No O Unsure .... Anxiety / Panic attacks / Phobias ____________________
O Yes O No O Unsure .... Depression ____________________
O Yes O No O Unsure .... Suicidal thoughts or attempts ____________________
O Yes O No O Unsure .... Aggressive behavior ____________________
O Yes O No O Unsure .... ADD / ADHD ____________________
O Yes O No O Unsure .... Developmental disability (MR) ____________________
O Yes O No O Unsure .... Cerebral palsy (CP) ____________________
O Yes O No O Unsure .... Other ____________________

Dental History:

O Yes O No O Unsure .... Loose Teeth ____________________
O Yes O No O Unsure .... False teeth / Bridges / Crowns ____________________
O Yes O No O Unsure .... Other ____________________

Other Conditions:

O Yes O No O Unsure .... Premature birth ____________________
O Yes O No O Unsure .... Cleft lip or palate: bilateral / unilateral ____________________
O Yes O No O Unsure .... Visual impairment / Contact use ____________________
O Yes O No O Unsure .... Glaucoma ____________________
O Yes O No O Unsure .... Hearing impairment ____________________
O Yes O No O Unsure .... Chronic pain ____________________
O Yes O No O Unsure .... Headache / Migraine ____________________
O Yes O No O Unsure .... Surgery complications ____________________
O Yes O No O Unsure .... Skin disorders / Eczema / Body piercing ____________________
O Yes O No O Unsure .... Other ____________________

Female Patients:

O Yes O No O Unsure .... Pregnant ____________________
O Yes O No O Unsure .... Using birth control pills ____________________
O Yes O No O Unsure .... Post-menopausal ____________________

Signature of person completing form:____________________ Date of completion: ____________________