



4. Please list all previous surgeries or dental procedures requiring anesthesia.

Surgical or Dental Procedure Requiring Anesthesia	Year

5. Any difficulties or complications with previous ANESTHESIA or surgery?  YES  NO

Anesthetic Complications	YES	NO
Severe Nausea or Vomiting		
Difficulty waking up		
Awareness while under anesthesia		
Difficult intubation (insertion of breathing tube)		
Malignant hyperthermia (you or your family) -- uncontrolled very high fevers		
Blood relative had major complication		
Other: _____		

6. Have you ever had HEART, CIRCULATION of BLOOD PRESSURE problems?  YES  NO

HEART, CIRCULATION of BLOOD PRESSURE problems?	YES	NO
High blood pressure		
Angina or chest /arm/jaw pain		
High Cholesterol		
Leg or neck artery blockage		
Heart attack		
Congestive heart failure		
Heart murmur/heart valve problem		
Irregular heart beat or palpitations		
Defibrillator		
Born with a heart problem		
Other heart condition _____		

# Anesthesia Patient Health Questionnaire

Initial Here \_\_\_\_\_

7. Do you have difficulty climbing two flights of stairs without stopping?

YES  NO

8. Have you ever had a specialized heart test or heart procedure?

YES  NO

Specialized heart test or heart procedure?	YES	NO
Carotid Doppler Study		
Holter monitor		
Stress test		
Heart catheterization		
Echocardiogram		
Cardiac stent? DATE _____		
Heart nuclear scan		
Other test or procedure _____		
Have you been told any of these tests were abnormal?		

9. Have you ever had breathing problems or a lung condition?

YES  NO

Breathing problems or a lung condition?	YES	NO
Asthma		
Emphysema or COPD		
History of pneumonia		
Chronic cough		
Sleep apnea		
Bronchitis		
Recent cold, sore throat (last 2 weeks)		
Use oxygen		
Shortness of breath		
Use CPAP or BiPAP		
Other lung or breathing problems? _____		

10. Have you ever had a brain, nerve, muscle or mental health condition?

YES  NO

Brain, nerve, muscle or mental health condition?	YES	NO
Stroke		
Seizures or epilepsy		
Paralysis		

# Anesthesia Patient Health Questionnaire

Initial Here \_\_\_\_\_

Brain, nerve, muscle or mental health condition?	YES	NO
Numbness or weakness		
Multiple sclerosis		
Neuropathy		
Tremors		
Parkinsonism		
Loss of bladder or bowel control		
Muscle disease		
Headache/Migraines		
Anxiety		
Depression		
Other: _____		

11. Have you ever had any liver or digestive problems?  YES  NO

Liver or digestive problems?	YES	NO
Ulcer		
Hiatal Hernia or Acid Reflux Disease (Heart Burn)		
Gallbladder Problems		
Hepatitis		
Yellow Jaundice		
Cirrhosis		
Difficulty Swallowing		
Unintentional Weight Loss		
Other: _____		

12. Have you ever had a kidney or prostate condition?  YES  NO

Kidney or prostate condition?	YES	NO
Chronic Bladder or Kidney Infection		
Kidney Stone		
Diminished Kidney Function/Kidney Failure		
Blood or Peritoneal Dialysis		
Prostate Enlargement or Prostate Cancer		
Other: _____		

Anesthesia Patient Health Questionnaire

Initial Here \_\_\_\_\_

13. Have you ever had blood or clotting disorder?  YES  NO

Blood or clotting disorder?	YES	NO
Anemia		
History of blood transfusion		
Blood clotting disorder		
Sickle cell trait or disease		
Transfusion reaction		
Bruising without reason		
Blood clots in legs or lungs		
Use blood thinners		
Other: _____		

14. Have you had diabetes, thyroid, or endocrine disorder?  YES  NO

Diabetes Treated with:

Diet

Pills

Insulin

Thyroid Disease:

High

Low

Prednisone or Steroid Use

YES

NO

Other: \_\_\_\_\_

15. Have you ever had arthritis, spine, joint, or connective tissue problems?  YES  NO

Arthritis, spine, joint, or connective tissue problems?	YES	NO
Degenerative arthritis		
Osteoporosis		
Spine problems: If so, check below.		
Neck		
Upper Back		
Lower Back		
Rheumatoid arthritis		
TMJ/difficulty opening mouth		
Neck stiffness or pain with neck movement		
Fibromyalgia/chronic fatigue		
Fractures		
Other: _____		

# Anesthesia Patient Health Questionnaire

Initial Here \_\_\_\_\_

16. For Women:

Date of Last Menstrual Period; \_\_\_\_\_

If pregnant, How many weeks? \_\_\_\_\_

If pregnant, Who is your OB? \_\_\_\_\_

17. Did you ever, or do you use tobacco, drink alcohol or use illicit drugs?  YES  NO

Use tobacco, drink alcohol or use illicit drugs?	YES	NO
Cigarette Smoking		
Packs per day _____ Years _____		
Cigar or pipe smoking		
Alcohol: Drinks per day _____		
Treated for alcoholism in the past?		
Marijuana		
Cocaine/Crack		
Methamphetamines		
Other: _____		

18. Have you had an organ transplant of any kind?  YES  NO

Organ transplant of any kind?	YES	NO
Heart		
Lung		
Liver		
Kidney		
Pancreas		
Other: _____		

19. Do you have any of the following implants?  YES  NO

Implants?	YES	NO
Artificial joints		
Pacemaker		
Defibrillator - AICD		
Cardiac Stent		
Vascular Stent		
Medication Pump		
Electrical Stimulator - nerve, diaphragm, brain....		

20. Other medical conditions:  YES  NO

Other medical conditions:	YES	NO
Hearing loss		
Vision loss or blindness		
Glaucoma		
Hearing aids		
Contact lenses		
Dental bridge		
Dentures		
Loose teeth		
Capped teeth/veneers		
Dental implants		
Tongue or body piercing		
Do you have a skin condition?		
Other: _____		

21. Have you been hospitalized or been to the ER in the last 12 months?  YES  NO

22. Have you had an EKG in the last 6 months?  YES  NO

23. Have you had a Chest X-ray in the last 12 months?  YES  NO

24. Have you ever been hospitalized over one week?  YES  NO

25. Have you seen someone other than the surgeon in preparation for this dental procedure or surgery?  
(Internal medicine, Pulmonologist or Cardiologist?) If yes, what is their name and contact information?

Name	Phone	Last seen

26. Is there anything that needs to be addressed prior to your dental procedure or surgery?

Anesthesia Patient Health Questionnaire

Initial Here \_\_\_\_\_

28. How would you rate your health?

- Healthy
- Mild Disease
- Severe Disease
- Severe Disease that is a constant threat to life

IF YOU HEALTH IS RATED AT SEVERE DISEASE OR SEVERE DISEASE THAT IS A CONSTANT THREAT TO LIFE, YOU PROCEDURE MAY NOT BE PERFORMED AT THE DENTIST OR DOCTOR OFFICE. YOUR PROCEDURE MUST BE PERFORMED AT AN ACCREDITED HOSPITAL OR AMBULATORY SURGERY CENTER

I HAVE READ AND ANSWERED ABOVE QUESTIONS TRUTHFULLY.

Relation to Patient:                      Self                       Parent                       Spouse

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

END OF QUESTIONNAIRE

## CONSENT FOR ANESTHESIA SERVICES

I, \_\_\_\_\_, acknowledge that my doctor has explained to me that I or my child will have an operation, diagnostic, or treatment procedure— medical or dental related. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, my doctor's preference, and my own preference. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

<input type="checkbox"/> Deep IV Sedation and General Anesthesia  (IV= Intravenous)	Expected Result	Total unconscious state, possible placement of a tube into the nose mouth and windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia

<input type="checkbox"/> Moderate/Conscious IV Sedation  (IV= Intravenous)	Expected Result	Total or partial amnesia, reduced anxiety and pain, Intermittent periods of brief unconsciousness  Able to follow commands
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	An unconscious state, depressed breathing, injury to blood vessels  Partial or total memory of the procedure  Advancement to General Anesthesia with associated risks.

I understand that my anesthesia may be advanced to DEEP IV SEDATION and GENERAL ANESTHESIA if Moderate IV Sedation is not effective as determined by my doctor or anesthesiologist.

I prefer that my anesthesia NOT BE advanced to Deep IV Sedation and General Anesthesia and stopping the procedure IF the procedure being performed safely permits me to be awakened.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_