PLEASANT VALLEY DENTISTRY

Pre- Sedation/Anesthesia Patient Self-Assessment Questionnaire

Patient Name: _____ Date of Birth: _____

Address: _____ Phone :_____

AGE: _____ SEX: _____ Other: _____

Proposed Surgery : _____

Primary Care physician name/phone # _____

Cardiologist/phone # _____

Pharmacy name/phone#/address _____

Other physician(s)/phone #_____

Your Weight _____ Your Height_____

List all previous operations and approximate dates: _____

_____

List all Allergies to medications, foods, latex and reactions experienced: _____

_____

_____

_____

List all Medications/Drugs you are supposed to take (include over the counter drugs, inhalers, herbals, aspirin, and supplements/vitamins):

_____

_____

_____

_____

_____

_____

Have you had any of the following tests? **(Circle)**: ECG ECHO/ultrasound of Heart Stress Test

Sleep Study Blood Work Pulmonary Function Tests CT/MRI Scans Other

(Circle) Yes or No to each question:

Have you taken steroids (prednisone or cortisone) in the last year?..... YES NO

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Have you ever smoked? _____packs per day for _____years……..YES NO

Do you still smoke? _____packs per day……..YES NO

Do you drink alcohol?.....YES NO

If so, how much? _____

Did you ever have COVID- 19 ? ……Yes No

If so, when?_____ Were you hospitalized?.....Yes No

If yes, what were the dates? _____

Do you feel better now?.....Yes No

Do you use or have you ever used illegal drugs?.....YES NO

Can you walk up two flights of stairs without stopping?.....YES NO

Have you had any problems with your heart? ……..YES NO

(Chest pain or pressure, heart attacks, abnormal ECG, skipped beats, murmur, palpitations, heart failure)

Do you have high blood pressure?.....YES NO

Do you have Diabetes? ……YES NO

Have you had any Lung or Chest problems? ……YES NO

(Circle all that apply) (shortness of breath, emphysema, bronchitis, asthma, TB)

Do you currently have a cold, fever, flu or cough?.....YES NO

Describe any changes recently_____

Do you have any bleeding problems from nose, gums, tooth extractions, surgery? ……..YES NO

Do you have Sickle Cell disease or trait? (circle) ……YES NO

Liver Problems (Cirrhosis, Hepatitis A, B, C; Jaundice)……..YES NO

Kidney Problems : Circle any that apply (Failure, Dialysis, Stones)……..YES NO

Digestive/Stomach Problems (GERD, heartburn, ulcers, hiatal hernia)……..YES NO

Arthritis (Rheumatoid, Osteo)……YES NO

Back/Neck Pain, Spinal Issues? ……YES NO

Thyroid Gland Disorders?.....Yes NO

Siezures/Convulsions/Fits?.....YES NO

Neurological Problems such as Stroke, paralysis, numbness? ……YES NO

Do you suffer from dizziness, motion sickness, vertigo ?.....YES NO

Cramping in Legs when walking? ……..YES NO

Problems with hearing, vision, memory? ……..YES NO

Have you ever been treated with chemotherapy or radiation therapy?.....YES NO

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List indication and dates of treatment_____

Could you be pregnant?.....YES NO Last menstrual period began:_____

Have YOU ever had problems with anesthesia?.....YES NO

Describe problems: _____

Have any BLOOD RELATIVES had any problems with Anesthesia such as Malignant Hyperthermia or Pseudocholinesterase Deficiency?.....Yes No

If Yes please explain_____

Do your physical abilities limit your daily activities?.....YES NO

Do you snore when sleeping? .....YES NO

Do you have sleep apnea?.....YES NO

Do you exercise, walk, or play sports regularly?.....Yes No

If so what do you do?_____

List any other medical problems:_____

_____

What is your occupation?_____

Additional comments or questions for the doctor?_____

_____

It is very important to your health and safety that you are straightforward and accurate about your answers to the above questions. Sedation and anesthesia for dentistry and oral surgery is no different than for any other medical procedure and carries the same risks. It is important that we know your complete medical history.

Thank you.

I confirm that I have read through the form and that the information I have provided is correct and accurate to the best of my knowledge.

Signature _____ Date: _____

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