SCOTTSDALE
DENTAL ANESTHESIA

Name:____ Date of Birth:______________

Sex: _____Male______Female______Prefer not to say. Height:_____ Weight:______ Phone number:______________

Address:____City:__________________ State:__________

If Pt is a Minor (under age 18) or pt has change in power of attorney, please indicate:__________________________

Allergies to medications, foods, supplements:____

Please List all medications taken (prescribed and over the counter):_______________________________________

____

Cardiovascular:

Yes No High Blood Pressure

Yes No Coronary Artery Disease (CAD)

Yes No Congestive Heart Failure (CHF)

Yes No Peripheral Vascular Disease

Yes No Atrial Fibrillation

Yes No Heart Attack. When?__________

Yes No Chest Pain/Angina: How often?________
If yes, how treated?_________________

Yes No Murmur/ History of Rheumatic Fever

Yes No Pacemaker/ Implanted Defibrillator

Respiratory:

Yes No Asthma. Last ER visit?__________

Yes No COPD

Yes No Sleep Apnea/CPAP/BiPAP

Yes No Shortness of Breath

Endocrine:

Yes No Thyroid Disease: Hypo or Hyper

Yes No Diabetes: Type I or Type II
(circle) Insulin Pills Diet Controlled

Hematologic:

Yes No HIV/AIDs/Sexually Transmitted Disease

Yes No Hepatitis (circle) A B C

Yes No Sickle Cell: Disease or Trait

Yes No Excessive Bleeding/ Easy Bruising/ Blood Thinner

Yes No History of Blood Clots/ DVT

Neurological:

Yes No Down-Syndrome/Autism/Special needs
If Yes, please describe:_____________________

Yes No Stroke or TIA: When?________________

Yes No Paralysis. Where?_______________

Yes No Epilepsy. Last seizure?________________

Yes No Parkinson's Disease

Yes No Restless Leg Syndrome

Yes No Alzheimer's/ Dementia: Please describe cognitive level:__________________________

Other Neurological Condition:__________________________

GastroIntestinal:

Yes No Hiatal Hernia

Yes No Acid Reflux (GERD)

Yes No Hepatitis: Indicate Type:_______

Yes No Other GI/Liver problems?___________________

Musculoskeletal:

Yes No Arthritis: Rheumatoid or Osteo

Yes No Back or Neck Pain

Genitourinary:

Yes No Kidney Disease. Acute or Chronic
If yes, dialysis?____________________________

General:

Yes No Do you **Smoke**? How Often?_______________________

Yes No Do you use **Alcohol**? How Often?____________________

Yes No Recreational Drug Use?_________________________________

Yes No (Female Only) Pregnant? Date of last menstrual cycle?_____________

Questions?
Call: 602.320.5102
Email: ScottsdaleDentalAnesthesia@gmail.com

History & Physical: Surgical History

Have you (the patient) undergone any surgical procedures requiring any forms of anesthesia? Please list all surgeries, starting most recently.

1.____

2. ____

3.____

Do you (the patient) or patients' family have any complications or reaction to anesthesia? Please elaborate below:

____

____

Do you (the patient) or the patient's family have any history of Malignant Hyperthermia? No Yes (if yes, please elaborate above)

History & Physical: Questionnaire

1. Patients Primary Care Physician. Please complete the following info regarding your (the patient) primary care treatment: Practice Name:______________________________ Address: ______________________________ Phone Number: ________________ Last Appointment Date: ________________

2. Are you (the patient) being treated by any other medical professionals other than your primary care physician?
Yes No

3. Patients Specialty Care Physician. Please complete the following info regarding all medical professionals from whom you (the patient) are receiving treatment:
   1. Practice Name:__________________Specialty:________Phone Number:_______ Last Appointment Visit Date:_____What are you being treated for?______________________
   2. Practice Name:__________________Specialty:________Phone Number:_______ Last Appointment Visit Date:_____What are you being treated for?______________________
   3. Practice Name:__________________Specialty:________Phone Number:_______ Last Appointment Visit Date:_____What are you being treated for?______________________

4. Have you (the patient) had any of the following symptoms in the past 2 weeks?

Yes No Coughing: Yes No Fever:

Yes No Nasal/Chest Congestion: Yes No Vomiting:

Yes No Runny Nose:

5. Are you (the patient) taking any medications, supplements, vitamins, or herbal remedies (Prescription or Over the Counter)? Yes No

If so, please describe type and reason for use:.____

____

6. Which of the following activities are you (the Patient) able to do?

No Exercise (walking only)

Light Exercise (ability to walk up two flights of stairs without rest)

Moderate Exercise (light jogging/light workout)

Extreme Exercise (playing basketball for 1hr)

Additional Description:____-

7. Have you (the patient) experienced any of the following:

Chest Pain on exertion or at rest: Yes No

Shortness of breath on exertion or at rest: Yes No

Fainting/Syncope: Yes No

8. Do you (the patient) have any other medical conditions not mentioned above?______________________________________

____

9. Are you (the patient) pregnant or possibly pregnant?

No Yes Maybe

(Please be advised there are serious risks to the unborn child if you receive anesthetics while pregnant, such as birth defects, brain death, and spontaneous abortion.)

10. Please provide any additional commentary you would like to relay to the anesthesiologist.___________________________________

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_

History & Physical: Emergency Contact Info

Name:____Phone Number:__________________________

Relationship to Patient: ____

For office/provider use only:

Reviewed by:____________________________________ Date: ________

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