



SCOTTSDALE
DENTAL ANESTHESIA

Name: _____ Date of Birth: _____

Sex: Male ___ Female ___. 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: _____

Referring Dental Provider & Office: _____

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

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? _____



SCOTTSDALE
DENTAL ANESTHESIA

Yes No Excessive Bleeding/ Easy Bruising/ Blood Thinner

Yes No Recreational Drug Use? _____

Yes No History of Blood Clots/ DVT

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

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: _____



SCOTTSDALE
DENTAL ANESTHESIA

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. _____

History & Physical: Emergency Contact Info

Name: _____ Phone

Number: _____

Relationship to Patient:

For office/provider use only:

Reviewed by: _____ Date: _____