Date:

Patient Name:

As discussed with you, your dental treatment may benefit of administration of IV (intravenous) drugs to achieve a moderate state of sedation (anesthesia).

I will provide the anesthesia services and ensure your safety and relaxation, while your dentist team will provide the clinical aspects of your dental care.

In preparation for the procedure, please complete the Health History attached and return it to me via email. I will review it and call you to discuss it, as well as answer any questions that you might have.

Should you have any questions, please don't hesitate to ask.

Alex Denes, DDS
Master of the College of Sedation in Dentistry
Alex@DenesDDS.com
www.DentalSedation.net
310-528-5840 (please text if no answer)

Anesthesia Health History

Name _____ Phone number: _____Date of Birth_____ Date:

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, for what reason? _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Venereal Disease	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking: (add additional sheet if needed)

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin, Ibuprofen or Tylenol …..…… No Yes
d. Codeine, Valium® or other sedatives…… No Yes
e. Latex or Metals
f. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____

Doctor (Print Name) *Doctor Signature* *Date*