EPIONE Dental Anesthesiology
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BLUE

PRE-OPERATIVE ANESTHESIA EVALUATION (confidential)

PATIENT INFORMATION

Date:_____

Name_____ Date of Birth:_____
Address:_____ City:_____ State:_____ ZIP:_____
Home phone number:_____ Cell number:_____ Email:_____
Age:_____ Gender:_____Weight:_____ Height:_____ BMI:_____
Occupation:_____ SSN:_____
Primary physician:_____ Phone:_____
Specialist physician:_____ Phone:_____
Dentist:_____ Phone:_____
Escort:_____ Phone:_____
Planned procedure:_____ Date:_____

MEDICAL HISTORY

Are you in good health?	Y	N
Has there been a change in your health within past 1 year?	Y	N
My last physical examination was on _____		
Are you now under the care of physician?	Y	N
Have you been seriously ill in the past 5 years?	Y	N
Have you been hospitalized in the past 5 years?	Y	N
Are you taking any **medications**?	Y	N
If yes, please list _____		
_____		
_____		
_____		
Do you have or had any of the following?		
cardiovascular disease	Y	N
damaged/ artificial heart valves	Y	N
rheumatic heart disease	Y	N
heart attack	Y	N
angina, coronary insufficiency	Y	N
high blood pressure	Y	N
arteriosclerosis	Y	N
stroke	Y	N
Do you have chest pain upon exertion?	Y	N
Are you ever short of breath after exercise?	Y	N
Do your ankles swell?	Y	N
Do you have inborn heart defects?	Y	N
Do you have a cardiac pacemaker?	Y	N
Do you have any **allergy**?	Y	N
If yes, please list_____		
_____		
_____		
_____		
Do you have sinus trouble?	Y	N
Do you have **asthma** or hay fever?	Y	N
Do you have fainting spells or seizures?	Y	N
Do you have persistent diarrhea or weight loss?	Y	N
Do you smoke or chew tobacco?	Y	N
If yes how much? _____ppd_____years		
Do you drink alcohol?	Y	N
If yes how much? _____drinks_____week		
Do you use any illicit drugs?	Y	N
Please list_____		
Have you ever had bad experience in a dental office?	Y	N
If yes please list_____		
_____		
_____		

Do you have **diabetes**?	Y	N
Do you have hepatitis or **liver disease**?	Y	N
Do you have AIDS or HIV infection?	Y	N
Do you have **thyroid problems**?	Y	N
Do you have arthritis or painful swollen joints?	Y	N
Do you have stomach ulcer or hyperacidity?	Y	N
Do you have **kidney** problems?	Y	N
Do you have **respiratory problems**, emphysema?	Y	N
Do you have or had tuberculosis?	Y	N
Do you have persistent cough or cough with blood?	Y	N
Do you have persistent **swollen lymph glands**?	Y	N
Do you have low blood pressure?	Y	N
Do you have sexually transmitted disease?	Y	N
Do you have **epilepsy** or other neurological disease?	Y	N
Do you have problems with mental health?	Y	N
Do you have or had cancer?	Y	N
Do you have problems with the immune system?	Y	N
Have you had abnormal bleeding?	Y	N
Have you ever required a blood transfusion?	Y	N
Do you have any **blood disorders,** anemia?	Y	N
Have you ever had any treatment for tumor growth?	Y	N
Are you allergic or have you had reaction to:		
local anesthetic	Y	N
penicillin or other antibiotics	Y	N
sulfa drugs	Y	N
barbiturates, sedatives, sleeping pills	Y	N
aspirin	Y	N
iodine	Y	N
codeine or other narcotics	Y	N
other	Y	N
Have you ever had a serious head injury?	Y	N
Do you have problems with your cervical spine?	Y	N
Do you have recurrent headaches?	Y	N
Do you have hoarseness?	Y	N
Do you have eating disorder?	Y	N
Do you have gastroesophageal reflux disease?	Y	N
Do you have emotional problems?	Y	N
Do you suffer from osteoporosis?	Y	N
Do you have obstructive **sleep apnea**?	Y	N
Do you wear contact lenses?	Y	N
Do you have any **disability**?	Y	N
Are you developmentally delayed?	Y	N
Do you have any hearing impairment?	Y	N
Are your immunizations to date?	Y	N
Do you have any disease not listed above?	Y	N

WOMEN

Are you **pregnant** or trying to get pregnant? Y N
Are you taking birth control pills? Y N
Do you have any problems with your menstruation? Y N
Are you nursing? Y N

CHILDREN

Were there any complications during the pregnancy? Y N
Your child was born at:_____weeks
Complications during the newborn period:_____
How was your child delivered VAGINAL C-SECTION
If C-SECTION, reason:_____

ANESTHESIA HISTORY

Have you ever had administered any type of anesthesia? Y N
If yes please list_____
_____
Have you ever had any **complications with anesthesia**? Y N
If yes please list_____
_____
Had anybody from your family have any problems with anesthesia? Y N
If yes please list_____
_____
Do you have a family history of malignant hyperthermia? Y N
Do you have history of prolonged nausea and vomiting after anesthesia? Y N
Do you have a history of difficult airway? Y N
Do you have problems with your temporomandibular joint? Y N
Do you have limited mouth opening? Y N
Did you ever had any operation or radiation in your maxillofacial region? Y N
Did you undergo any ENT procedures before? Y N
Have you ever had tracheostomy procedure done? Y N
Do you have a history of difficult IV start? Y N
Have you ever had any abnormal reaction to medications? Y N

GUARDIAN INFORMATION

Name_____ Date of Birth:_____
Address:_____ City:_____ State:_____ ZIP:_____
Home phone number:_____ Cell number:_____ Email:_____
Age:_____ Gender:_____Occupation:_____ SSN:_____

EMERGENCY CONTACT INFORMATION

Name_____ Date of Birth:_____
Address:_____ City:_____ State:_____ ZIP:_____
Home phone number:_____ Cell number:_____ Email:_____

*I certify that I have provided an accurate and complete personal and medical history and I have not knowingly omitted any information. I understand that providing incomplete or inaccurate information may negatively influence the treatment and treatment results. Should there be any change in either my health status or any other information I have provided, I will advise my dental anesthesiologist. I authorize **Dr. Jana Sabo** to request to have diagnostic procedures performed as may be required to determine the necessary treatment. I understand that information provided from or to my medical doctor pr another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy.*

_____	_____	_____
Patient name	Patient signature	Date
_____	_____	_____
Guardian name	Guardian signature	Date
_____	_____	_____
Witness name	Witness signature	Date