

**PRE-OPERATIVE ANESTHESIA EVALUATION (confidential)**

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date: \_\_\_\_\_  
 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	Do you have <b>diabetes</b> ?	Y N
Has there been a change in your health within past 1 year?	Y N	Do you have hepatitis or <b>liver disease</b> ?	Y N
My last physical examination was on _____		Do you have AIDS or HIV infection?	Y N
Are you now under the care of physician?	Y N	Do you have <b>thyroid problems</b> ?	Y N
Have you been seriously ill in the past 5 years?	Y N	Do you have arthritis or painful swollen joints?	Y N
Have you been hospitalized in the past 5 years?	Y N	Do you have stomach ulcer or hyperacidity?	Y N
Are you taking any <b>medications</b> ?	Y N	Do you have <b>kidney</b> problems?	Y N
If yes, please list _____		Do you have <b>respiratory problems</b> , 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 or had any of the following?		Do you have persistent <b>swollen lymph glands</b> ?	Y N
<b>cardiovascular disease</b>	Y N	Do you have low blood pressure?	Y N
damaged/ artificial heart valves	Y N	Do you have sexually transmitted disease?	Y N
rheumatic heart disease	Y N	Do you have <b>epilepsy</b> or other neurological disease?	Y N
heart attack	Y N	Do you have problems with mental health?	Y N
angina, coronary insufficiency	Y N	Do you have or had cancer?	Y N
high blood pressure	Y N	Do you have problems with the immune system?	Y N
arteriosclerosis	Y N	Have you had abnormal bleeding?	Y N
stroke	Y N	Have you ever required a blood transfusion?	Y N
Do you have chest pain upon exertion?	Y N	Do you have any <b>blood disorders</b> , anemia?	Y N
Are you ever short of breath after exercise?	Y N	Have you ever had any treatment for tumor growth?	Y N
Do your ankles swell?	Y N	Are you allergic or have you had reaction to:	
Do you have inborn heart defects?	Y N	local anesthetic	Y N
Do you have a cardiac pacemaker?	Y N	penicillin or other antibiotics	Y N
Do you have any <b>allergy</b> ?	Y N	sulfa drugs	Y N
If yes, please list _____		barbiturates, sedatives, sleeping pills	Y N
_____		aspirin	Y N
_____		iodine	Y N
Do you have sinus trouble?	Y N	codeine or other narcotics	Y N
Do you have <b>asthma</b> or hay fever?	Y N	other	Y N
Do you have fainting spells or seizures?	Y N	Have you ever had a serious head injury?	Y N
Do you have persistent diarrhea or weight loss?	Y N	Do you have problems with your cervical spine?	Y N
Do you smoke or chew tobacco?	Y N	Do you have recurrent headaches?	Y N
If yes how much? _____ppd _____years		Do you have hoarseness?	Y N
Do you drink alcohol?	Y N	Do you have eating disorder?	Y N
If yes how much? _____drinks _____week		Do you have gastroesophageal reflux disease?	Y N
Do you use any illicit drugs?	Y N	Do you have emotional problems?	Y N
Please list _____		Do you suffer from osteoporosis?	Y N
Have you ever had bad experience in a dental office?	Y N	Do you have obstructive <b>sleep apnea</b> ?	Y N
If yes please list _____		Do you wear contact lenses?	Y N
_____		Do you have any <b>disability</b> ?	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 <b>pregnant</b> or trying to get pregnant?	Y N	Do you have any problems with your menstruation?	Y N
Are you taking birth control pills?	Y N	Are you nursing?	Y N

**CHILDREN**

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

**ANESTHESIA HISTORY**

Have you ever had administered any type of anesthesia?	Y N
If yes please list _____	
Have you ever had any <b>complications with anesthesia</b> ?	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 or 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