dentTIVA

# Anesthesia Patient Health Questionnaire Initial Here_____

Patient's Name: _____DOB: _____ Age: _____ Weight_____lb.

Gender: Male Female

Surgeon: _____

Date of Surgery: _____

Contact Numbers: Home _____

E-mail Address: _____

Patient Address:_____

_____

City:_____

State:_____Zip Code:_____

1. List all current Medications and herbal supplements that you that you take: ☐ I take no medications

| Name | Dosage | Frequency |
|---|---|---|
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2. List all allergies to food, medications and other substances (latex rubber, shellfish, Iodine):

_____

_____

_____

_____

☐ I do not have any known allergies

3. Have you ever had dental or surgical procedures requiring sedation or general anesthesia?

☐ YES ☐ NO

List on next page.

4. Please list your previous surgeries or dental procedures requiring anesthesia.

| Surgical or Dental Procedure Requiring Anesthesia | Year |
|---|---|
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5. Any difficulties or complications with previous ANESTHESIA or surgery?

| Anesthetic Complications | YES | NO |
|---|---|---|
| Severe Nausea or Vomiting | | |
| Difficulty waking up | | |
| Awareness while under anesthesia | | |
| Difficult intubation (insertion of breathing tube) | | |
| Malignant hyperthermia (you or your family) -- uncontrolled very high fevers | | |
| Blood relative had major complication | | |
| Other: _____ | | |

6. Have you ever had HEART, CIRCULATION of BLOOD PRESSURE problems? ☐ YES ☐ NO

| HEART, CIRCULATION of BLOOD PRESSURE problems? | YES | NO |
|---|---|---|
| High blood pressure | | |
| Angina or chest /arm/jaw pain | | |
| High Cholesterol | | |
| Leg or neck artery blockage | | |
| Heart attack | | |
| Congestive heart failure | | |
| Heart murmur/heart valve problem | | |
| Irregular heart beat or palpitations | | |
| Defibrillator | | |
| Born with a heart problem | | |
| Other heart condition _____ | | |

7. Do you have difficulty climbing two flights of stairs without stopping? ☐ YES ☐ NO

Continue on to next page until page 8.

8. Have you ever had a specialized heart test or heart procedure? ☐ YES ☐ NO

| Specialized heart test or heart procedure? | YES | NO |
|---|---|---|
| Carotid Doppler Study | | |
| Holter monitor | | |
| Stress test | | |
| Heart catheterization | | |
| Echocardiogram | | |
| Cardiac stent? DATE _____ | | |
| Heart nuclear scan | | |
| Other test or procedure _____ | | |
| Have you been told any of these tests were abnormal? | | |

9. Have you ever had breathing problems or a lung condition?

| Breathing problems or a lung condition? | YES | NO |
|---|---|---|
| Asthma | | |
| Emphysema or COPD | | |
| History of pneumonia | | |
| Chronic cough | | |
| Sleep apnea | | |
| Bronchitis | | |
| Recent cold, sore throat (last 2 weeks) | | |
| Use oxygen | | |
| Shortness of breath | | |
| Use CPAP or BiPAP | | |
| Other lung or breathing problems?_____ | | |

10. Have you ever had a brain, nerve, muscle or mental health condition? ☐ YES ☐ NO

| Brain, nerve, muscle or mental health condition? | YES | NO |
|---|---|---|
| Stroke | | |
| Seizures or epilepsy | | |
| Paralysis | | |
| Numbness or weakness | | |
| Multiple sclerosis | | |
| Neuropathy | | |

Continue on to next page until page 8.

| Brain, nerve, muscle or mental health condition? | YES | NO |
|---|---|---|
| Tremors | | |
| Parkinsonism | | |
| Loss of bladder or bowel control | | |
| Muscle disease | | |
| Headache/Migraines | | |
| Anxiety | | |
| Depression | | |
| Other:_____ | | |

11. Have you ever had any liver or digestive problems? ☐ YES ☐ NO

| Liver or digestive problems? | YES | NO |
|---|---|---|
| Ulcer | | |
| Hiatal Hernia or Acid Reflux Disease (Heart Burn) | | |
| Gallbladder Problems | | |
| Hepatitis | | |
| Yellow Jaundice | | |
| Cirrhosis | | |
| Difficulty Swallowing | | |
| Unintentional Weight Loss | | |
| Other:_____ | | |

12. Have you ever had a kidney or prostate condition? ☐ YES ☐ NO

| Kidney or prostate condition? | YES | NO |
|---|---|---|
| Chronic Bladder or Kidney Infection | | |
| Kidney Stone | | |
| Diminished Kidney Function/Kidney Failure | | |
| Blood or Peritoneal Dialysis | | |
| Prostate Enlargement or Prostate Cancer | | |
| Other:_____ | | |

Continue on to next page until page 8.

13. Have you ever had blood or clotting disorder? ☐ YES ☐ NO

| Blood or clotting disorder? | YES | NO |
|---|---|---|
| Anemia | | |
| History of blood transfusion | | |
| Blood clotting disorder | | |
| Sickle cell trait or disease | | |
| Transfusion reaction | | |
| Bruising without reason | | |
| Blood clots in legs or lungs | | |
| Use blood thinners | | |
| Other:_____ | | |

14. Have you had diabetes, thyroid, or endocrine disorder? ☐ YES ☐ NO

Diabetes Treated with:

Diet ☐ Pills ☐ Insulin ☐

Thyroid Disease: High ☐ Low ☐

Prednisone or Steroid Use YES ☐ NO ☐

Other:_____

15. Have you ever had arthritis, spine, joint, or connective tissue problems? ☐ YES ☐ NO

| Arthritis, spine, joint, or connective tissue problems? | YES | NO |
|---|---|---|
| Degenerative arthritis | | |
| Osteoporosis | | |
| Spine problems: If so, check below. | | |
| Neck | | |
| Upper Back | | |
| Lower Back | | |
| Rheumatoid arthritis | | |
| TMJ/difficulty opening mouth | | |
| Neck stiffness or pain with neck movement | | |
| Fibromyalgia/chronic fatigue | | |
| Fractures | | |
| | | |
| | | |
| Other:_____ | | |

Continue on to next page until page 8.

16. For Women:

Date of Last Menstral Period; _____

If pregnant, How many weeks? _____

If pregnant, Who is your OB? _____

17. Did you ever, or do you use tobacco, drink alcohol or use illicit drugs? ☐ YES ☐ NO

| Use tobacco, drink alcohol or use illicit drugs? | YES | NO |
|---|---|---|
| Cigarette Smoking | | |
| Packs per day _____ Years _____ | | |
| Cigar or pipe smoking | | |
| Alcohol: Drinks per day _____ | | |
| Treated for alcoholism in the past? | | |
| Marijuana | | |
| Cocaine/Crack | | |
| Methamphetamines | | |
| Other:_____ | | |

18. Have you had an organ transplant of any kind? ☐ YES ☐ NO

| Organ transplant of any kind? | YES | NO |
|---|---|---|
| Heart | | |
| Lung | | |
| Liver | | |
| Kidney | | |
| Pancreas | | |
| Other:_____ | | |

19. Do you have any implants? ☐ YES ☐ NO

| Implants? | YES | NO |
|---|---|---|
| Artificial joints | | |
| Pacemaker | | |
| Defibrillator - AICD | | |
| Cardiac Stent | | |
| Vascular Stent | | |
| Medication Pump | | |
| Electrical Stimulator - nerve, diaphragm, brain.... | | |

Continue on to next page until page 8.

20. Other medical conditions: ☐ YES ☐ NO

| Other medical conditions: | YES | NO |
|---|---|---|
| Hearing loss | | |
| Vision loss or blindness | | |
| Glaucoma | | |
| Hearing aids | | |
| Contact lenses | | |
| Dental bridge | | |
| Dentures | | |
| Loose teeth | | |
| Capped teeth/veneers | | |
| Dental implants | | |
| Tongue or body piercing | | |
| Do you have a skin condition? | | |
| Other:_____ | | |

21. Have you been hospitalized or been to the EMERGENCY ROOM in the last 12 months? ☐ YES ☐ NO

22. Have you had an EKG in the last 6 months? ☐ YES ☐ NO

23. Have you had a Chest X-ray in the last 12 months? ☐ YES ☐ NO

24. Have you ever been hospitalized over one week? ☐ YES ☐ NO

25. Have you seen someone other than the surgeon in preparation for this dental procedure or surgery? (Internal medicine, Pulmonologist or Cardiologist?) If yes, what is their name and contact information?

| NAME | PHONE | DATE LAST SEEN |
|---|---|---|
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26. Is there anything that needs to be addressed prior to your dental procedure or surgery?

_____

Continue on to next page until page 8.

28. How would you rate your health?

- ☐ Healthy
- ☐ Mild Disease
- ☐ Severe Disease
- ☐ Severe Disease that is a constant treat to life

IF YOU HEALTH IS RATED AT SEVERE DISEASE OR SEVERE DISEASE THAT IS A CONSTANT THREAT TO LIFE, YOU PROCEDURE MAY NOT BE PERFORMED AT THE DENTIST OR DOCTOR OFFICE. YOUR PROCEDURE MUST BE PERFORMED AT AN ACCREDITED HOSPITAL OR AMBULATORY SURGERY CENTER

I HAVE READ AND ANSWERED ABOVE QUESTIONS TRUTHFULLY.

Relation to Patient: Self ☐ Parent ☐ Spouse ☐

Signature: _____ Date: _____

END OF QUESTIONNAIRE