Anesthesia Connections Preoperative Medical History Questionnaire

Our number one priority at Anesthesia Connections is patient safety; please fill out this form as completely as possible so that we may plan your anesthetic accordingly. A member of the Anesthesia Connections team may contact you prior to the procedure to discuss the anesthetic.

Today's Date: _____ **Procedure Date:** _____ **Procedure Type:** _____

Office/Physician name where you will be having your procedure: _____

Name of person completing this form and relationship to patient: _____

Patient Name: _____ **Patient Date of Birth:** _____ **Date of Last Visit:** _____

Gender: Male Female If Female, could you possibly be pregnant? _____

Height: _____ **Weight:** _____

Primary Care Physician Name & Number: _____

Current Medications and Dosages: ☐ None ***Remember to include Birth Control, Blood Thinners, Weight Loss, Non-prescription Medications***

_____

_____

Allergies: ☐ No Known Medication Allergies ☐ Latex Allergy/Sensitivity ☐ History of Malignant Hypothermia

_____

Previous Surgical or Non-invasive procedures requiring Anesthesia or sedation (please list all prior procedures and dates):

_____

Complications/Concerns with prior anesthetics (please be as detailed as possible):

_____

Past Medical History:

☐ Negative **Cardiac:** ☐ Heart Attack ☐ Coronary Artery Disease (CAD) ☐ Hypertension
☐ Heart Murmur ☐ Angina/Chest Pain ☐ Atrial Fibrillation
Other: _____ Cardiologist: _____

☐ Negative **Respiratory:** ☐ Asthma ☐ Sleep Apnea ☐ Snoring ☐ COPD/Emphysema
☐ Recent (3 weeks) pneumonia/bronchitis/respiratory infection
Other: _____ Pulmonologist: _____

☐ Negative **Neuro/ENT:** ☐ Stroke/TIA ☐ Glasses/Contact Lenses ☐ Loose Teeth
☐ Dental Appliances
Other: _____

☐ Negative **GI/Hepatic:** ☐ Acid Reflux/Hiatal Hernia ☐ Hepatitis
Other: _____

☐ Negative **Endocrine:** ☐ Diabetes ☐ Hyperthyroid or Hypothyroid
Other: _____

☐ Negative **Heme/Other:** ☐ Cancer ☐ Bleeding or Clotting Problems ☐ Anemia
Other: _____

☐ Negative **Musculoskeletal:** ☐ Back/neck Problems ☐ Joint Problems ☐ Walking Aids
☐ Pre-existing pains, numbness or weakness in arms or legs
Other: _____

☐ Negative **Renal/Urinary Problems:** ☐ Prostate Problems ☐ Incontinence
Other: _____

Please provide contact phone numbers and convenient times to call you prior to the scheduled procedure:

_____

Please provide the name and phone number of the individual to accompany the patient home following the procedure:

_____

Preoperative Instructions: Do Not Eat or Drink anything for 8 Hours before your procedure unless specifically directed by your Anesthesiologist. If you take blood pressure or diabetes medicines, please discuss with your anesthesiologist before your procedure. If you take any other medications on a regular basis, you may take those medications with a sip of water in the morning before your procedure.

Anesthesia Connections: www.anesthesiaconnectionsdental.com

Please Fax this form to: (888) 831-1024