

HEALTH HISTORY RD

← Select

Name:		Address:		
Last	First	Number & Street		
City	State	Zip	Home #	Business #
Date of Birth	Sex	Height	Weight	lbs. E-mail:
Single	Married	Name of Spouse:	<input type="checkbox"/>	<input type="checkbox"/>
Closest Relative	Phone	Referring Dentist:		

If you are completing this form for another person, what is your relationship to that person? _____

How do you feel about dental treatment?
How do you feel about anesthesia?

← Please Select

For the following questions select **YES** or **NO** whichever applies. Your answers are for our records only and will be considered confidential. **YES NO**

1. Are you in good health? _____
2. Has there been any change in your general health within the past year?.....
3. My last complete physical was on _____
4. Are you now under the care of a physician?.....
If so, what is the condition being treated? _____
5. The name, city and state of my physician is _____
Phone _____
Fax _____
6. Have you had any illness or operation that required hospitalization?.....
If so, what was the illness or operation? _____
7. Do you have or have you had any of the following diseases or problems?
 - a. Damaged heart valves, artificial heart valves, knee or hip replacement, plastic or artificial arteries?
 - b. Congenital heart defect(s) or murmur?
 - c. Cardiovascular disease: heart trouble, heart attack, coronary insufficiency, coronary occlusion, hypertension arteriosclerosis, or stroke?
 - i) Do you have chest pain upon exertion?.....
 - ii) Are you ever short of breath after mild exercise?
 - iii) Do your ankles swell?
 - iv) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?.....
 - v) Do you have a cardiac pacemaker?
 - vi) Do you have an arrhythmia or an irregular heart beat?.....
 - d. Has your **physician** ever told you to take antibiotics prior to dental therapy for a medical condition?
 - If YES, why? _____
 - e. Sinus trouble?
 - f. Asthma, hay fever, hives, or skin rash? (circle which one).....
 - g. Fainting spells, seizures or epilepsy? If YES, state cause:
 - h. Diabetes?
 - i. Is your mouth frequently dry or do you urinate more than six times per day?.....
 - j. Hepatitis, jaundice or liver disease?
 - k. Have you ever been told not to donate blood? If YES, why?.....
 - l. A.I.D.S., ARC, or tested positive for HIV?
 - m. Arthritis or inflammatory rheumatism?
 - n. Stomach ulcers?
 - o. Kidney trouble?
 - p. Tuberculosis or a persistent cough or cough up blood?.....
 - q. Low blood pressure?

- r. Have you ever had venereal disease?.....
- s. Have you ever had a nervous breakdown or psychotherapy?.....
- t. Do you have a history of alcoholism or drug dependence?.....
- u. Other:
- 8. Have you taken any "recreational" drugs in the past year such as cocaine, crack, marijuana, LSD?
If so what? _____ When? _____
- 9. How much do you smoke per day? _____ How many years have you smoked? _____
- 10. How much alcohol do you drink per day averaged over the week?
- 11. Do you bleed easily, bruise easily, or have you had abnormal bleeding with previous extractions or surgery?.....
- 12. Do you have any blood disorder such as anemia?.....
- 13. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck?.....
- 14. Are you taking any of the following? Select **YES** or **NO** **Yes** **No** **Drug** **Dose** **Reason**
Antibiotics or sulfa drugs?.....
Anticoagulants (Blood thinners).....
Medicine for high blood pressure (hypertension).....
Cortisone (steroids).....
Tranquilizers
Antihistamines
Aspirin or Ibuprofen
Insulin, tolbutamide (Orinase) or similar drug
Digitalis or drugs for heart trouble
Nitroglycerin
Oral contraceptive or other hormonal therapy
Any other prescription or non-prescription medication....
- 15. Are you allergic or have you reacted adversely to: **Please Circle Drug** "[GU" P Q
Local or general anesthetics (which one?).....
Penicillin, sulfa drugs or other antibiotics
Sulfites, eggs, soybean
Barbiturates, sedatives, Valium, Demerol, codeine, or sleeping pills (which one?)
Aspirin, Advil or Ibuprofen
Iodine
Other? _____
- 16. To the best of your knowledge, has any blood relative had a bad reaction to any anesthetic?.....
- 17. Have you ever had any trouble associated with any previous surgery or anesthetic not mentioned?.....
If so, what? _____
- 18. Are you taking, or have you EVER taken, the diet drugs fenfluramine or dexfenfluramine? (fen-phen)
- 19. Do you have any disease, condition or problem not mentioned above ?.....
If so, what? _____

WOMEN

- Is there any possibility that you are you pregnant?.....
- Are you a nursing mother?.....
- Do you have any problems associated with your menstrual period?.....

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.

SIGN HERE

SIGNATURE OF PATIENT (OR GUARDIAN)

DATE

REVIEWED BY: R. O. DAVIES, DDS

DATE

FOR DOCTOR'S USE ONLY

HEAD & NECK: ATR WITH FROM OTHER ___ NASAL: CLEAR OTHER _____ EYES: PEERL OTHER ORAL: 3CM+
HEART: RRR WITHOUT M _____ OTHER: _____
CONSULTATION: MD DDS PLAN: LCS MAC STANDBY ASA: I II III
PRE-MED: 12.5 MG AMBIENCR HS 2MG LORAZEPAM 1 HR PRIOR
RIDE: SPOUSE OTHER _____ Last DDS _____
_____ BP / _____ RESP. EDP PAIN LENGTH

INFORMED CONSENT AND RECORDS RELEASE FOR ANESTHESIA

The following is provided to inform patients of the choices and risks involved with having treatment under anesthesia. This information is not presented to make patients apprehensive but to enable them to be better informed concerning their treatment. In fact, since starting his practice in 1977, Dr. Davies has never had a reported serious complication. The choices for anesthesia are: local anesthesia alone, local with intravenous sedation, or general anesthesia. These are administered depending upon each individual patient's unique requirements.

The side effect seen most frequently of any intravenous infusion is phlebitis which occurs only 2-4 percent of the time. Phlebitis is a raised, tender, hardened, inflammatory response at the site of the injection which can have onset from 24-48 hours up to two weeks after the procedure. The inflammation usually resolves with local application of warm (100°F) moist heat, yet tenderness and a hard lump may be present up to a year.

I, _____, hereby authorize and request **RONALD O. DAVIES, D.D.S.** to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic or anesthetics (from local to general) by any method that is deemed suitable by Dr. Davies. It is the understanding of the undersigned that Dr. Davies is an independent contractor and consultant and will have full charge of the administration and maintenance of the anesthesia, which is an independent function of the surgery/dentistry. I also understand that Dr. Davies has no input or responsibility for the dentistry to be performed or the diagnosis or treatment planning involved in the dentistry.

I have been informed and understand that occasionally there are complications of the local anesthesia and medications, including but not limited to: pain, hematoma, temporary or permanent numbness of the face, teeth, tongue, lip or gums, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, stroke, and heart attack. I further understand and accept the risk that very rare complications may require hospitalization that could result in death. I have been made aware that the risks associated with local anesthesia, intravenous sedation, and general anesthesia vary. Of the three, local anesthesia is usually considered to have the least risk and general anesthesia the greatest risk. However, it must be noted that local anesthesia alone may not be appropriate for every patient and every procedure and that local and intravenous anesthesia may be safer than local alone.

I understand that anesthetics, medication, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Davies of any possibility of pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For similar reasons I understand that I must inform Dr. Davies if I am a nursing mother.

Because medication, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination which can be increased by the use of alcohol or other drugs, I have been advised not to operate any vehicle or hazardous device for at least twenty-four (24) hours or longer until fully recovered from the effects of the anesthetic, medications, and drugs that may have been given to me for my care. I have been advised not to make any important decisions until after full recovery from the anesthesia. I understand that those with a history of chemical or alcohol dependency have a possible risk of relapse after anesthesia and should take appropriate precautions and support options.

I have been fully advised of and accept the possible risks and dangers of anesthesia. I acknowledge the receipt of, understand and agree to follow both pre and post-operative anesthesia instructions. It has been explained to me and I understand that there is no warranty or guarantee as to any result and/or cure. I have had the opportunity to ask questions about my anesthesia and I am satisfied with the information provided to me. **I also request that my physicians release to Dr. Ronald Davies any information he desires regarding my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to my surgery and anesthetic management** also authorize Dr. Davies to speak with my spouse, parents or adult children regarding any phase of my treatment.

I have received a copy of instructions and this consent.

Signed _____

Date _____

SIGN HERE

Address _____

Witness _____

WITNESS

These anesthesia instructions supersede any instructions given by your dentist.

INSTRUCTIONS PRIOR TO ANESTHESIA

For your safety, all of these instructions must be strictly adhered to before commencing with the anesthesia. Neglecting any of the following may compel the doctor to cancel the start of treatment and a cancellation charge may be incurred.

Eating and Drinking

Patients for morning treatment shall have no food or liquid after midnight. Those for afternoon treatment may have a light meal six hours before the scheduled appointment, and have only clear liquids like apple-juice or water, up to four(4) hours before treatment time.

Medications

Medications normally taken, should be taken unless otherwise agreed upon by this office, and may be taken only with a sip of water. Antibiotic pre-medications should always be taken when prescribed and at least one hour before arriving. Inform Dr. Davies of any change in the patient's medications or health. Do not have blood drawn or venipunctures within one week of surgery without contacting Dr. Davies.

Clothing

Wear short sleeves, flat shoes and warm comfortable long pants and socks. Contact lenses must not be worn to the office. Remove all makeup, perfume, powders, lotions, oils, watches and jewelry before arriving. Leave all valuables at home.

Transportation

A responsible adult must drive the patient, escort them into the office, and wait at least 30 minutes. They should have both primary and alternate ride information available. A change in their health, especially the development of a cold or fever, is very important. For their safety, they may be reappointed for another day. Inform Dr. Davies of any change in health prior to the appointment

Note! :

The use of "STREET DRUGS" (MARIJUANA, COCAINE, HEROIN, etc.) is strictly forbidden for several weeks prior to the administration of any anesthetic and until full recovery is achieved. The reason for these restrictions is safety. The literature has reported that the mixture of "Street Drugs" and anesthetic agents has resulted in very serious complications including death. No smoking for 12 hours prior to surgery.

INSTRUCTIONS FOLLOWING ANESTHESIA

After returning home, the patient should rest for the first day and be carefully watched.

Getting Home

The patient must be accompanied home by a responsible adult. They must not plan to drive a vehicle or operate potentially dangerous equipment for twenty-four (24) hours after their treatment. They may not leave alone by bus or taxi. Companion services are available for these duties at their expense.

Home

A responsible adult must be with the patient until fully recovered. Companion services are available for these duties at their expense.

Discomfort

Muscle aches and a sore throat may occur similar to the flu. This is nothing to be alarmed about. It is common after general anesthesia and will normally disappear in 24 to 36 hours. It is far less common with conscious sedation. Post operative pain medication must come from your dentist.

Drinking and Smoking

The patient should bring a cola and ensure to drink before they leave. When they get home the more they eat and drink, the better they will feel the next day. Do not allow them to sleep and miss another meal. Small amounts of food and beverages should be taken repeatedly. During the day the patient should sleep no more than three hours without urinating, eating and drinking. Be sure to have them urinate once again before retiring for the evening. Food should be soft and not hot or spicy. No alcoholic beverages for 24 hours, NO SMOKING for 24 hours. (Pain medication or antibiotics on an empty stomach is the main cause of nausea)

Intravenous Site

A very small percentage of all patients experience post-operative tenderness and/or redness in their hand or arm which is a chemical phlebitis associated with the intravenous infusion. If this occurs please call Dr. Davies at 949-362-9690. To reduce the incidence of phlebitis patients should keep the arm that had the intravenous line elevated and apply warm (100°F) moist heat as much as possible. If a phlebitis does occur the patient should take an anti-inflammatory agent.

Seek Advice:

If vomiting occurs and persists beyond four hours.
If their temperature remains elevated beyond 24 hours.
If any other matter causes concern.

PLEASE CONTACT YOUR DENTIST FOR ALL PAIN MEDICATIONS

Ronald O. Davies, DDS (949) 362-9690 email: info@DentalAnesthesia.com