

PLEASE...

Do not remove staple

HEALTH HISTORY RD



Mr. Mrs. Ms. Dr.

Name Last First Address Number & Street

City State Zip Home # Business #

Date of Birth Sex Height Weight lbs. E-mail:

Social Security No. Single Married Name of Spouse:

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? not at all anxious, anxious, very anxious, extremely anxious.

How do you feel about anesthesia? not at all anxious, anxious, very anxious, extremely anxious.

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

- 1. Are you in good health? YES NO
2. Has there been any change in your general health within the past year? YES NO
3. My last complete physical was on
4. Are you now under the care of a physician? YES NO
5. The name, city and state of my physician is Phone Fax
6. Have you had any illness or operation that required hospitalization? YES NO
7. Do you have or have you had any of the following diseases or problems? PLEASE CIRCLE
a. Damaged heart valves, artificial heart valves, knee or hip replacement, plastic or artificial arteries? YES NO
b. Congenital heart defect(s) or murmur? YES NO
c. Cardiovascular disease: heart trouble, heart attack, coronary insufficiency, coronary occlusion, hypertension arteriosclerosis, or stroke? Please Circle YES NO
i) Do you have chest pain upon exertion? YES NO
ii) Are you ever short of breath after mild exercise? YES NO
iii) Do your ankles swell? YES NO
iv) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
v) Do you have a cardiac pacemaker? YES NO
vi) Do you have an arrhythmia or an irregular heart beat? YES NO
d. Has your physician ever told you to take antibiotics prior to dental therapy for a medical condition? YES NO
If YES, why?
e. Sinus trouble? YES NO
f. Asthma, hay fever, hives, or skin rash? (circle which one) YES NO
g. Fainting spells, seizures or epilepsy? If YES, state cause: YES NO
h. Diabetes? YES NO
i. Is your mouth frequently dry or do you urinate more than six times per day? YES NO
j. Hepatitis, jaundice or liver disease? YES NO
k. Have you ever been told not to donate blood? If YES, why? YES NO
l. A.I.D.S., ARC, or tested positive for HIV? YES NO
m. Arthritis or inflammatory rheumatism? YES NO
n. Stomach ulcers? YES NO
o. Kidney trouble? YES NO
p. Tuberculosis or a persistent cough or cough up blood? YES NO
q. Low blood pressure? YES NO

- r. Have you ever had venereal disease? YES NO
 s. Have you ever had a nervous breakdown or psychotherapy? YES NO
 t. Do you have a history of alcoholism or drug dependence? YES NO
 u. Other: _____
8. Have you taken any "recreational" drugs in the past year such as cocaine, crack, marijuana, LSD? YES NO
 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? YES NO
12. Do you have any blood disorder such as anemia? YES NO
13. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? YES NO
14. Are you taking any of the following? **Circle YES or NO**
- | | YES | NO | Drug | Dose | Reason |
|---|-----|----|------|------|--------|
| Antibiotics or sulfa drugs? | YES | NO | | | |
| Anticoagulants (Blood thinners) | YES | NO | | | |
| Medicine for high blood pressure (hypertension) | YES | NO | | | |
| Cortisone (steroids) | YES | NO | | | |
| Tranquilizers | YES | NO | | | |
| Antihistamines | YES | NO | | | |
| Aspirin or Ibuprofen | YES | NO | | | |
| Insulin, tolbutamide (Orinase) or similar drug | YES | NO | | | |
| Digitalis or drugs for heart trouble | YES | NO | | | |
| Nitroglycerin | YES | NO | | | |
| Oral contraceptive or other hormonal therapy | YES | NO | | | |
| Any other prescription or non-prescription medication | YES | NO | | | |
15. Are you allergic or have you reacted adversely to: **Please Circle Drug** Please Circle
- Local or general anesthetics (which one?) YES NO
 Penicillin or other antibiotics YES NO
 Sulfa drugs YES NO
 Barbiturates, sedatives, Valium, Demerol, codeine, or sleeping pills (which one?) YES NO
 Aspirin, Advil or Ibuprofen YES NO
 Iodine YES NO
 Other IE: EGGS or EGG PRODUCTS? YES NO
16. To the best of your knowledge, has any blood relative had a bad reaction to any anesthetic? YES NO
17. Have you ever had any trouble associated with any previous surgery or anesthetic not mentioned? YES NO
 If so, what? _____
18. Are you taking, or have you EVER taken, the diet drugs fenfluramine or dexfenfluramine? (fen-phen) YES NO
19. Do you have any disease, condition or problem not mentioned above? YES NO
 If so, what? _____

WOMEN

- Is there any possibility that you are you pregnant? YES NO
 Are you a nursing mother? YES NO
 Do you have any problems associated with your menstrual period? YES NO

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.

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 WITHOUTM _____ OTHER: _____
 CONSULTATION: MD DDS PLAN: LCS MAC STANDBY ASA: I II III
 PRE-MED: 12.5 MG AMBIEN CR HS 2MGLORAZEPAM 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 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, conscious 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 sedation 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 major or 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.** I also authorize Dr. Davies to speak with my spouse, parents or children regarding any phase of my treatment.

I have received a copy of instructions and this consent.

Signed _____ Date _____

Address _____

Witness _____

INFORMED CONSENT 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 basically three: local anesthesia alone, conscious sedation, or general anesthesia. These are administered depending upon each individual patient's medical requirements.

The side effect seen most frequently of any intravenous infusion is phlebitis. This side effect occurs in from 2-4 percent of patients. 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 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 route 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 only, which is an independent function from the surgery/dentistry. I also understand that Dr. Davies has no responsibility for the dentistry to be performed or the diagnosis or treatment planning involved in the dentistry.

I 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 may even result in death. I am now aware that the risks associated with local anesthesia, conscious 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 may not be appropriate for every patient and every procedure and that local and sedation 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 will not 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 will not make any major or 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 will take appropriate precautions and support options.

I am now 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 and understand that failure to do so may result in charges. I understand that there is no warranty or guarantee as to any result and/or cure. **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. I also authorize Dr. Davies to speak with my spouse, parent or children about any phase of my treatment.**

This is the patient's copy.

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

Do not eat **anything** for six (6) hours before your scheduled appointment. Patients for morning treatment shall have no food or liquid after midnight. Those for afternoon treatment shall have only **clear** liquids like apple-juice or water, no later than 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 your medications. Do not have blood drawn or venipunctures within one week of surgery.

Clothing

Wear short sleeves, flat shoes and warm comfortable pants. Contact lenses must not be worn to the office. **Remove all nail polish, makeup, perfume, powders, lotions, oils, watches and jewelry before arriving.** Leave all valuables at home. Remove long acrylic nails on two fingers, each hand.

Transportation

A responsible adult must drive you, escort you into the office, and wait at least 30 minutes. You should have both primary and alternate ride information available.

Change in Health

A change in your health, especially the development of a cold or fever, is very important. For your safety, you may be reappointed for another day. Inform Dr. Davies of any change in health prior to your 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 your 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 by a responsible adult and arrangements must be made to contact a responsible adult at the time of discharge. Do not plan to drive a vehicle or operate potentially dangerous equipment for twenty-four (24) hours after your treatment. You will not be allowed to leave alone by bus or taxi. Nursing services are available for these duties at your expense.

Home

A responsible adult must be with the patient until the next day. Nursing services are available for these duties at your expense.

Pain

Muscle aches and a sore throat may occur similar to the flu. This is nothing to be alarmed about. It is very 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 surgeon.

Drinking and Smoking

Dr. Davies suggests the patient bring some 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 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 intravenous infusion. If this occurs please call Dr. Davies at 949-362-9690. To prevent phlebitis all 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 the temperature remains elevated beyond 24 hours.
If any other matter causes concern.

TRANSPORTATION INFORMATION

PATIENT'S NAME: _____

As you know, a responsible adult must drive you to and from your dental appointment and a responsible adult must stay with you overnight. Advise your driver that they are expected to escort you to the office and wait for about 30 minutes. If you can arrange to have your ride home be the same person who spends the night with you we can give them your post surgical instructions.

Unless your ride waits for you in the dental office during your entire appointment, we will need the following information and an alternate driver.

We realize that it is extremely unlikely that your ride will fail to return for you, but about twice a year, accidents, car trouble, and illness force us to contact the alternate driver. Without an alternate driver, those patients would have had to have been admitted to a hospital overnight. Therefore it is in everyone's best interest that you complete the following:

I did not complete the information below because my ride is waiting the entire time.

Signed: _____

Driver's Name: _____ Phone: _____

Time (in minutes) needed by driver to return to dental office: _____

Alternate Driver's Name: _____ Phone: _____

Phone # where you may be reached after your appointment: _____

Phone # of your pharmacy: _____