Sweet Dreams, LLC — Office-based Anesthesia Services

Rev. Oct. 2015

PATIENT INFORMATION

Complete this section. Please print.

Date______________ Name ____ Age_______ Birthday ______________ Sex ______

Weight _____ lbs. Allergies to Medicines ____________________________ Medications taken routinely ____________________

Proposed Procedure ____ Dentist _________________________

Previous Anesthetics/Surgeries ____ Anesthetic Complications ______________

Is there a history of anesthesia problems in your family? ____

Has the patient experienced any of the following: (Check appropriate spaces)

___Large Tonsils	___High Blood Pressure	___Kidney Disease	___Tuberculosis
___Snoring/Sleep Apnea	___Irregular Heart Beat	___Diabetes/Hypoglycemia	___Cancer/HIV
___Shortness of Breath/Asthma	___Rheumatic Fever/Murmur	___Liver Disease/Hepatitis	___Bleeding Disorders
___Exposure to Smoking	___Heart Attack/Chest Pain	___Thyroid Problems	___Alcohol Abuse
___Chronic Cough	___Stroke/Blood Clots	___Numbness/Paralysis	___Substance Abuse
___Hiatal Hernia/Reflux	___Epilepsy/Seizures	___Headaches ___Other ________________________	

Any loose, cracked, or chipped teeth?________ Any dentures or dental appliances?________ Glasses/Contact Lenses? ________
Disabilities/Restrictions/Preferences ____
Do you or any member of your family have any concerns or questions about anesthesia? ___________________________________

Consent for Anesthesia: I give my consent for anesthesia to be provided as requested by my dentist. I certify that I have read, understand, and have fully complied with the pre-anesthesia instructions and intend to fully follow the post-anesthesia instructions. I understand that there are certain risks associated with anesthesia. Although rare, patients can suffer allergic reactions, circulatory or respiratory failure, organ damage, nerve damage, brain damage, or even death. If the patient requires transport to or treatment at another facility, I understand that I am financially responsible for the costs incurred. I understand that my questions and concerns will be addressed by my dentist or anesthetist.

Signed: ____Relationship ______________________Date ________________

PRE-OP PHYSICAL EVALUATION

To be completed by anesthetist.

NPO Since _____________ Spo2 _____ HR _____ RR _____
HEENT ________________________________ Temp. _____
ASA Airway Classification I II III
ASA Anesthesia Risk Class I II III E

Cardiovascular ____
Respiratory ____
Neuro/Endocrine ____
Extremities/Skin ____

Comments ____

Anesthetic Plan: ____ I/M / IV Sedation. Plan and risks discussed with pt./s.o., questions answered, accepted by pt/s.o. ____

Signed ____ Date ____________________ Time __________

Post Operative Note: ____

Signed ____ Date _____________________ Time __________