Pusch Ridge Anesthesia
Dental Anesthesia Services

Health History Form

*Please read carefully and fill out each section completely. Leave nothing blank, if something doesn't apply state N/A or none.

Patient Name:_____ Date of Birth:_____ Age: _____Height: _____Weight: _____lbs.

Drug Allergies: _____

Medication List (include herbals & vitamins):_____

_____

Prior Surgeries and Anesthetics: _____

Previous complications or problems with anesthesia? ___Y/ N___ Family history of problems with anesthesia ___Y/ N___

If yes to either please explain: _____

Scheduled Procedure: _____ Doctor: _____

Past Medical History: Check any of the following that apply, if negative check none

Cardiovascular (Heart): ___None
___ High Blood Pressure
___ High Cholesterol
___ Abnormal Heart Rhythm
___ Chest Pain
___ Heart Murmur
___ Congetive Heart Failure (CHF)
Ejection Fraction (EF): _____
___ Pacemaker
___ Previous Heart Attack
Date:_____Stents: _____
___ Coronary Artery Disease
___ Heart Valve Disease
___ Peripheral Vascular Disease
___ Other:_____

Respiratory (Lungs): ___ None
___Recent cold, cough, strep throat
Date:_____
___ Asthma
___ COPD
___ Emphysema
___ Home Oxygen use
___Chronic Cough
___ Smoking/Vaping
Pack per day: _____
Years used: _____
Current: ____ Date Quit: ____
___ Sleep Apnea ____ CPAP
___ Snoring
___ Seasonal Allergies
___Bronchitis/Pnuemonia
___ Shortness of Breath
___ Other: _____

Neurologic (Brain)/Musculoskeletal: ___None
___ Stroke/TIA (mini stroke)
Date:_____ Residual problems: _____
___ Seizure Disorder
Date of last Seizure: _____
___ Neuropathy
___ Headaches/Migraines
___ Loss of Consciousness (Syncope)
___ Arthritis
___ Degenerative Disc Disease
___ Numbness/Weakness Hands or Feet
___ Paralysis
___ Chronic Back Pain
___ Fibromyalgia
___ Scoliosis
___ Cerebral Palsy
___ Muscular Dytrophy
___ Other: _____

Stomach/Liver/Kidneys: _____None
___ Acid Reflux/Heartburn/GERD
___ Peptic Ulcer Disease
___ Hiatal Hernia
___ Bowel Obstruction
___ Chronic Nausea/Vomiting
___ Liver Cirrhosis
___ Hepatitis__A __B __C
___ Fatty Liver
___ Chronic Kidney Disease
Stage:_____
___ End Stage Renal Disease (ESRD)
___ Dialysis: Dialysis Schedule: ____
___ Kidney Stones
___ Benign Prostatic Hyperplasia (BPH)
___ Urinary Retention
___ Other: _____

Endocrine: _____None
___ Diabetes
__ Type I __ Type II
__ Insulin Dependant __Oral Meds
Hemoglobin A1C: _____
___ Thyroid Disorder
__Hypothyroid __Hyperthyroid
___ Adrenal Disorder
___ Metabolic Disorder
___ Weight Loss treatment or surgery
(Wt loss medication Phentermine must be stopped 14 days before surgery)
___Other: _____

Blood/Bleeding Disorder: _____None
___ Anemia
___ Sickle Cell Disease
___ Deep Vein Thrombosis (DVT)
___ Pulmonary Embolism (PE)
___ Blood Transfusion History
Date: _____ Reason: _____
___ Easy Bruising, bleeding tendencies
___ HIV/AIDS
___ Other:_____

Other: ____None
___ Cancer- Type: _____
Treatment:_____
___ Depression/Anxiety
___ PTSD
___ Down's Syndrome
___ ADD/ADHD
___ Autism
___ Developmental Delay
___ Alcohol Use- Frequency:_____
Amount: _____
___ Subtance Abuse/Recreational Drugs
Substances Used: _____
Current:___ Past___
Date of last use:_____

Recent Tests/Labs/Doctor Visits: ____None
*If applicable report any abnormal findings & date of exam.
___ EKG- Results: _____
___ Echocardiogram-Results: _____
___ Cardiac Evaluation-Date:_____
___ Stress Test- Results:_____
___ Pulm Function Test:_____
___ Labs: Hemoglobin:_____
Hematocrit:_____
Platelet Count:_____
Potassium:_____
Sodium:_____
Creatinine:_____
BUN:_____
Blood Glucose: _____
___ Other:_____

I have read fully and completed this form to the best of my knowledge

Signature: _____ Date: _____

Preanesthesia Evalution/Assessment: ***Completed by Anesthesia Provider***

Pre-procedure Vital Signs: NIBP:____/____ HR: ____ SPO2:____ RR:____ Temp:_____ NPO since:_____

ASA Physical Status: __I __II__III
Mallampati Score: __I __II__III__IV
Anesthesia Technique/Plan:
__IV Sedation/Nasal Cannula
__ General Anesthesia/Intubation

Assessment

Cardiac: _____WNL___
Pulmonary: _____WNL___
Neurologic: _____WNL___
Airway/TeethNeck:_____
_____WNL___

Endocrine:_____WNL____
Stomach/Liver/Kidney:_____
_____WNL____
Bleeding disorder:_____ WNL____
Other:_____WNL____

Prior to procedure: chart reviewed, anesthetic plan discussed with patient and/or legal guardian, and all questions answered ___

Anesthesia Provider Signature: _____CRNA Date:_____ Time:_____

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Pusch Ridge Anesthesia
Dental Anesthesia Services

Informed Consent for Anesthesia Services

Initial

*Please read carefully, initial each section, and sign at bottom.

____ The following is to inform patients of choices and risks involved with having treatment under anesthesia. By involving Pusch Ridge Anesthesia you are choosing to have either deep sedation or general anesthesia with intubation. Most patients remain drowsy the remainder of the day. A responsible adult must be available to provide a ride and assistance home.

____ I understand anytime anesthesia is administered there are potential risks involved. Some mild and more common risks of anesthesia can include nausea, vomiting, temporary confusion, and sore throat (if intubation is performed). Rare complications of anesthesia can include but are not limited to: allergic reaction, phlebitis (redness and swelling at injection site), infection, bleeding, hoarseness, vocal cord damage, aspiration, pneumonia, headache, peripheral nerve injury, muscle soreness, paralysis, eye injury, awareness under anesthesia, heart attack, stroke, brain damage, coma, and death. If nasal intubation is performed complications can include nasal soreness, epistaxes, sinusitis, turbinectomy, and retropharyngeal perforation. It is normal and expected to experience throat soreness for one to two days after intubation.

____ I have informed my anesthesia provider of all my medical history, surgical history, prescription and non-prescription medication including herbals, and any recreational drug and/or alcohol use.

____ I understand that accidental dental injury is a potential complication of anesthesia. I have let my anesthesia provider know of any removable partials, bridges, or dentures and/or any loose, cracked, chipped, or otherwise damaged teeth. I agree the anesthesia provider cannot be held responsible for any dental injury that may occur during the anesthesia period.

____ I have been informed and intend to follow the pre and post anesthesia instructions including refraining from food for a period of 8 hours and clear liquids for 2 hours prior to the scheduled procedure time.

____ I have let my nurse anesthesiologist know of any known drug allergies or adverse reactions I have experienced in the past.

____ I certify that the nurse anesthesiologist has explained the anesthetic plan sufficiently and answered all of my questions regarding anesthesia.

Women of Childbearing Age:

____ I understand that anesthetics can be harmful to the unborn child and may cause birth defects or spontaneous abortion. I accept full responsibility for informing my nurse anesthesiologist of the possibility of being pregnant. By initialing I attest that I am not currently pregnant. I am advised to obtain a negative pregnancy test prior to receiving anesthesia. By signing this agreement I choose to proceed with the scheduled treatment under anesthesia and accept the risks and responsibilities of doing so.

I have read and understand the risks associated with the administration of anesthesia and agree to proceed

Printed Patient Name:_____

Signature:_____ Relationship to Patient:_____Date: _____