# Anaesthesia in Dentistry

*Anaesthesia, Prosthodontics & Restorative Dentistry*
Dr. Bruce Glazer

**MEDICAL ALERT:**

**Patient's Name:**
**HEIGHT:**
**WEIGHT:**
**DATE OF BIRTH:**

**IN CASE OF EMERGENCY NOTIFY:**

**MEDICAL-DENTAL HISTORY QUESTIONNAIRE ASA(☐) BP(☐) P(☐)**

Patient's Name_____

**Instructions:**
To receive treatment in this office you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in this office – to the best of your ability honest answers must be given. If you are unsure of the questions, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor. Some of the questions may not relate to your medical condition; in that event you are to write "N/A" (not applicable) in the space provided. All questioned must be answered. To properly evaluate your current health status it may be necessary for the dentist to contact other health professional. Included in this form is "Permission To Obtain and Release Information".

All information you supply on this form, and subsequent information from the interview by the dentist and anything received from your physician or any other source, will be held in the strictest confidence, and will not be disclosed without your permission.
1.Family physician:_____Phone #_____
Name, address & telephone #'s of other health professionals which you have seen in the past year
_____
_____

2. Date of your last physical examination_____
3. Have you ever now or in the past taken illegal drugs? If yes, what drugs and when were they taken? _____
Have you ever been treated for drug or alcohol dependency?_____When?_____

*Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal. This is especially true in regard to anaesthesia agents.*

4. Do you have AIDS, or are you HIV-positive? If yes, describe and provide current status:
_____
5. Do you have or have ever had venereal disease?_____

6. Have you ever had, or do you have hepatitis?_____
7. For females: Are you pregnant? If yes, when are you due?_____
8. For females: Are you taking the birth control pill?_____
***Note: There are drugs used in routine dental care that decrease the effectiveness of birth control pills.***

9. Are you taking any medications, non prescription drugs or herbal supplements? If yes, please specify.

_____
_____
_____

10. Have you ever had an allergic reaction to foods, medication, latex or rubber? If yes, describe.
_____

**Have you ever had or been treated for the following? If yes, please describe.**

11. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?
_____
12. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular heart beats?
_____
13. Stomach, liver or intestinal disease?_____
14. Abnormal blood pressure, excessive bleeding and anemia?_____
15. Breathing problem, asthma, tuberculosis, shortness of breath, hay fever?_____
16. Cancer, X-ray treatments, or chemotherapy?_____
17. Diabetes?_____
18. Kidney problems or renal dialysis?_____
19. A stroke, convulsions or fainting spells?_____
20. Tumors or growths?_____
21. Arthritis, rheumatism?_____
22. Prosthetic or artificial joint replacement?_____
23. Major operation?_____
24. Serious injury to your head or neck?_____
25. Consulted or treated by a psychiatrist or counselor?_____
26. Are you on a special diet? If yes, for what reason and describe._____
27. Do you smoke or chew tobacco products? Describe type and quantity_____

**DENTAL HISTORY**

**In respect to any previous dental treatment have you:**

28. Ever been told you should take an antibiotic prior to dental procedures?_____
29. Ever fainted?_____
30. Had an allergic reaction?_____
31. Had abnormal bleeding?_____
32. Any other complications during or following dental treatment? If yes, please describe._____
_____
33. Do your gums bleed on brushing or eating?_____
34. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose?_____
35. Are your teeth sensitive to hot, cold or pressure?_____
36. Do you grind or clench your teeth?_____
37. Do you have pain or clicking in the jaw joint around your ear?_____
38. Have your face muscles ever been sore?_____

39. Are there any sores or growths in your mouth?_____
40. Do any of your teeth ache?_____
41. Do you have any other dental complaint?_____
42. Do you wish to add any more pertinent medical-dental conditions other than all of the above?
_____
43. Do you get anxious prior to and/or during dental procedures?_____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

**Permission to Obtain and Release Health-Dental Information**
I, _____grant the right to Drs Glazer/Wyman/Markin to release and or request any records and information about my medical and dental history from and or to third party payers, and or other dental and health professionals.

**Permission to Obtain Financial Information**
I, _____authorize Drs Glazer/Wyman/Markin to obtain and/or exchange any personal information (with the exception of medical and dental history) with any personal information agent for the purpose of verifying my credit history.
To the best of my knowledge, the foregoing questions have been accurately answered.

**Person completing this form:**
Signature:
_____Date:_____

Print Name:
_____Witness:_____

If other than patient, indicate relationship:
_____

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