Medical History

Name:_____
Last First

Address:_____
Number and Street City State Zip Code

Phone: _____ _____ _____
Home Work Cellular

If patient is a minor: Father: Mother:

Date of Birth:_____ Age:_____ Sex:_____ Weight:_____ Height:_____

In the following questions circle YES or NO which ever applies. Your answers remain strictly confidential.

1. Are you in good health?---------- YES NO
2. Has there been any change in your general health with in the past year?---------- YES NO
3. My last physical was on _____
4. Are you now under the care of a physician?---------- YES NO
5. If yes what is the condition being treated_____
   a. The name of the physician_____ phone #_____
6. Have you had any serious illness or operation that required hospitalization---------- YES NO
   a. If yes what and when was the illness or operation _____
   _____
7. Do you have any of the following diseases or problems
   a. Damaged heart valves or artificial heart valves----------YES NO
   b. Congenital heart defect(s) or murmur----------YES NO
   c. Cardiovascular disease: heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis or hypertension (high blood pressure).---------- YES NO
      i. Do you have chest pain on 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?----------YES NO
      v. Do you have a cardiac pacemaker?----------YES NO
      vi. Do you have an arrhythmia or irregular heart beat?---------- YES NO
   d. Have you ever been told that you need to take antibiotics prior to dental treatment?---------- YES NO
   e. Stroke?---------- YES NO
   f. Sinus trouble?---------- YES NO
   g. Asthma?---------- YES NO
   h. Hayfever, hives, skin rash?---------- YES NO
   i. Seizures?---------- YES NO
   j. Diabetes?---------- YES NO
   k. Hepatitis, jaundice or liver disease?---------- YES NO
   l. Arthritis or inflammatory rheumatism?---------- YES NO
   m. Stomach ulcers?---------- YES NO
   n. Esophageal reflux?---------- YES NO
   o. Kidney trouble?---------- YES NO
   p. Tuberculosis or persistent cough?---------- YES NO
   q. Low blood pressure?---------- YES NO
   r. Venereal disease?---------- YES NO
   s. Psychological treatment?---------- YES NO
   t. Do you have a history of alcoholism or drug dependence?---------- YES NO
8. Have you taken any "recreational" drugs in the past year such as cocaine, crack, marijuana?-- YES NO
   a. If yes what? _____ When?_____
9. Do you smoke?---------- YES NO
   a. If yes how much? _____ How many Years?_____
10. On average how much alcohol do you drink per week?_____
11. Do you bleed easily, bruise easily or have had abnormal bleeding after surgery?---------- YES NO
12. Do you have any blood disorders such as anemia?---------- YES NO

13. Have you ever had surgery or x-ray treatment for a tumor, cyst, growth or other condition on your head and neck?---------- YES NO
14. Are you allergic to any foods or medications?---------- YES NO
    a. Please list and describe the reaction _____
    _____
15. Please list all medications that you take including over the counter and herbal medications
_____
_____
_____
16. Please list any surgeries and or anesthetics you have had and the dates_____
    _____
17. Has any blood relative had any bad reaction to any anesthetics?---------- YES NO
18. Do you have any disease, condition or problem not listed?---------- YES NO

Women
19. Are you pregnant?---------- YES NO
20. Do you have any problems associated with you menstrual period?---------- YES NO
21. Are you a nursing mother?---------- YES NO

I understanding that withholding any information about my health could seriously jeopardize my safety. 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

Date S: HPI:
ROS: HEENT:

Cardiac:

Pulm:

Liver:

Kidney:

Endo:

Neuro:

Meds

Aller:

SX/ Anest
SH:

O: Gen: Wt. BP: HR: S pO2

HEENT
Heart:
Lungs:

A: ASA_____

P:

Signature _____

Informed Consent for Anesthesia

I understand that the purpose of an informed consent is to make me aware of the choices and risks involved with having procedures performed under anesthesia so that I can make well informed decisions concerning my treatment. The choices of anesthesia are determined on an individual basis. The choices of anesthesia are: local anesthesia alone, IV conscious sedation and IV general anesthesia.

I hereby authorize and request Dr. Lenny Naftalin, D.D.S. or Dr. Andrew Young, D.D.S. to perform the anesthesia 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 route that is deemed suitable by Dr. Naftalin, or Dr. Young, who is an independent contractor and consultant. It is the understanding of the undersigned that Dr. Naftalin or Dr. Young, will have full charge of the administration and maintenance of anesthesia, and that this is an independent function from the surgery/ dentistry. I also understand that Dr. Naftalin or Dr. Young, has no responsibility for the dental treatment to be performed, the diagnosis, or the treatment planning involved. Dr. Naftalin's or Dr. Young's, sole attention and responsibility will be to render the optimal and safest anesthesia.

I have been informed and understand that occasionally there are anesthesia related complications, including but not limited to: pain, hematoma, numbness, swelling, bleeding, nausea, vomiting, delay in recovery, allergic reactions, laryngospasm, fluctuations in breathing pattern, heart rhythm and or blood pressure. I further understand and accept the extremely remote possibility that life-threatening complications may occur, requiring hospitalization. The most frequent side effects are drowsiness, nausea, vomiting and phlebitis.

I have been informed that most patients remain drowsy or sleepy following their surgery for the remainder of the day. Since anesthetics and other medications may cause drowsiness and incoordination, which can be enhanced by the use of alcohol and other drugs, I have been advised to abstain from their use until completely recovered from the effects of anesthesia and prescription medications. Additionally, I have been advised that patients receiving anesthesia should not operate any vehicle or hazardous device or make any major decisions for at least twenty-four (24) hours, or until completely recovered from the effects of anesthesia and prescription medications. Parents are advised of the necessity for direct parental supervision of children for 24 hours following their anesthesia.

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

I acknowledge the pre-operative fasting regulations and attest that they were followed. The patient has had nothing by mouth for at least eight (8) hours immediately before the appointment, the only exception being clear liquids, which may have been taken up to two (2) hours prior to the appointment.

I have been fully advised of and completely understand the alternatives to intravenous sedation and general anesthesia, and accept all possible risks and consequences. I acknowledge the receipt of, and completely understand both pre-anesthesia and post-anesthesia instructions. It has been explained to me and I accept that there is no warranty or guarantee as to any result and or cure. I have had the opportunity to ask questions about my or my child's anesthesia and am satisfied with the information provided to me. I hereby consent to the administration of anesthesia during my or my child's treatment or surgery.

_____

Name (please print)

_____

Signature date (Relationship to patient if a minor)

(If patient is a minor: signature of guardian)

_____