PRE-SEDATION RECORD

Date: _____

Name: _____

Date of Birth: Y____/M_____/D_____ ☐ Male ☐ Female Phone: Res. _____ Work _____

Home address: _____

City/Province: _____ Postal Code: _____

Person to notify in case of emergency: _____ Rel.: _____ Phone: _____

If applicable, name of parent or legally authorized representative: _____

MEDICAL HISTORY QUESTIONNAIRE

Have you ever had a minimal or moderate sedation? ☐ Yes ☐ No If yes, when? _____

Any complications? ☐ Yes ☐ No _____

Any history of familial sedation/anaesthetic complications? ☐ Yes ☐ No _____

Are you being treated for any medical condition at present or within the past two years? ☐ Yes ☐ No

If yes, please explain. _____

_____

When was your last visit to a physician? _____ Last complete medical examination? _____

Have you ever had a serious illness, accident, or required extensive medical care? ☐ Yes ☐ No If yes, please explain.

_____

Have you been hospitalized in the last five years? ☐ Yes ☐ No If yes, please explain. _____

_____

Are you taking any prescription or non-prescription drugs? ☐ Yes ☐ No If yes, what is the drug(s), dose(s), and for how long? _____

Have you ever had a reaction to any drug(s) or been advised against taking any kind of medication? ☐ Yes ☐ No

If yes, please explain. _____

Do you have any sensitivities or allergies ? ☐ Yes ☐ No If yes, please explain. _____

_____

Do you have any history of family disease? ☐ Yes ☐ No If yes, please explain. _____

_____

Indicate which of the following you presently have or ever had.

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
AIDS	☐	☐	Bleed easily	☐	☐	Congenital heart lesions	☐	☐
Alzheimers	☐	☐	Blood disorders	☐	☐	Congestive heart failure	☐	☐
Anemia	☐	☐	Blood in sputum	☐	☐	Cortisone/steroid therapy	☐	☐
Angina pectoris	☐	☐	Bronchitis	☐	☐	Diabetes	☐	☐
Arthritis/rheumatism	☐	☐	Cancer	☐	☐	Earaches (frequent)	☐	☐
Artificial heart valve	☐	☐	Cerebral palsy	☐	☐	Emphysema	☐	☐
Artificial joints	☐	☐	Changes in appetite	☐	☐	Epilepsy or seizures	☐	☐
Asthma	☐	☐	Chest pains	☐	☐	Fainting or dizzy spells	☐	☐
Balance problems	☐	☐	Circulation problems	☐	☐	Glandular disorders	☐	☐

	Yes	No		Yes	No		Yes	No
Glaucoma	☐	☐	Hypertension	☐	☐	Psychiatric treatment	☐	☐
Headaches (severe)	☐	☐	Impaired vision	☐	☐	Radiation treatment/ chemotherapy	☐	☐
Head/neck injuries	☐	☐	Infective endocarditis	☐	☐	Rheumatic/scarlet fever	☐	☐
Hearing difficulties	☐	☐	Jaundice	☐	☐	Shortness of breath	☐	☐
Heart disease or attack	☐	☐	Kidney disease	☐	☐	Sickle cell disease	☐	☐
Heart murmur	☐	☐	Leukemia	☐	☐	Sinus trouble	☐	☐
Heart pacemaker	☐	☐	Liver disease	☐	☐	Stomach/intestinal problems	☐	☐
Heart rhythm disorder	☐	☐	Lung disease	☐	☐	Stroke	☐	☐
Heart surgery	☐	☐	Malignant hyperthermia	☐	☐	Temperature intolerance	☐	☐
Hemophilia	☐	☐	Medical implant	☐	☐	Thyroid disease	☐	☐
Hepatitis A	☐	☐	Mental/nervous disorder	☐	☐	Tuberculosis	☐	☐
Hepatitis B	☐	☐	Mitral valve prolapse	☐	☐	Ulcers	☐	☐
Hepatitis C	☐	☐	Nosebleeds (frequent)	☐	☐	Venereal disease	☐	☐
Herpes	☐	☐	Organ transplant	☐	☐	Weight gain/loss	☐	☐
High/low blood pressure	☐	☐	Persistent cough	☐	☐	Other	☐	☐
Hodgkin's disease	☐	☐	Pulmonary edema	☐	☐			
Hyper(hypo) glycemia	☐	☐	Positive testing for HIV	☐	☐			

Do you smoke or use other forms of tobacco? ☐ Yes ☐ No _____

Do you have a history of alcohol and/or drug use? ☐ Yes ☐ No _____

Have you received treatment for alcohol or drug use? ☐ Yes ☐ No _____

Do you currently have, or have you had in the past, any disease, condition or problem not listed? ☐ Yes ☐ No _____

If yes, please explain. _____

Is there any problem or medical condition that you wish to discuss in private only? ☐ Yes ☐ No

WOMEN ONLY: Are you pregnant or suspect you might be? ☐ Yes ☐ No Anticipated delivery date? _____

Are you breast feeding? ☐ Yes ☐ No _____

Are you taking any birth control pills? ☐ Yes ☐ No _____

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

Signature _____ Date _____

☐ Patient ☐ Parent ☐ Legally Authorized Representative

Reviewed by dentist _____ Date _____