ALL STAR ANESTHESIA

Pre-Anesthesia Questionnaire

The information you supply below assists in the development of your anesthesia care plan. Please complete this questionnaire accurately and completely.

Patient Name _____ Date _____

DOB _____ Age _____ Weight _____ Height _____ Sex _____

Allergies _____

Current Medications (Prescription and Non-Prescription -- include all over-the-counter medications; herbal supplements; complementary or alternative medicines) _____

_____

Yes	No	
☐	☐	Is this your first time getting anesthesia?
		If no, list prior operations and/or procedures _____
		_____
☐	☐	Have you recently had a cold or the flu?
☐	☐	Are you allergic to latex (rubber) products?
☐	☐	Have you experienced chest pain?
☐	☐	Do you have a heart condition? Heart murmur?
☐	☐	Do you have hypertension (high blood pressure)?
☐	☐	Do you experience shortness of breath?
☐	☐	Do you have sleep apnea?
☐	☐	Do you have asthma, bronchitis, or any other breathing problem?
☐	☐	Do you (or did you) smoke? Packs/day _____ Number of years _____ Date you quit _____
☐	☐	Do you consume alcohol? Drinks/week _____
☐	☐	Do you take or have you taken recreational drugs?
☐	☐	Do you take herbal supplements, or complementary / alternative medicines? How recently?
☐	☐	(Men) Do you take or have you taken Viagra, Cialis, or other erectile disfunction medicines?
☐	☐	Have you taken cortisone (steroids) in the last six months?
☐	☐	Do you have diabetes?
☐	☐	Have you had hepatitis, liver disease, or jaundice?
☐	☐	Do you have a thyroid condition?
☐	☐	Do you have or have you had kidney disease?
☐	☐	Do you have ulcers or other stomach disorders?
☐	☐	Do you have a hiatal hernia?
☐	☐	Do you have back or neck pain?
☐	☐	Do you have numbness, weakness, or paralysis of your extremities?
☐	☐	Do you have any muscle or nerve disease?
☐	☐	Do you or any of your family have sickle cell trait?
☐	☐	Have you or any blood relatives had difficulties with anesthesia?
☐	☐	Do you have bleeding problems?
☐	☐	Do you have loose, chipped, false teeth, or bridgework?
☐	☐	Do you have any oral piercings, (such as studs or rings) in your tongue or lip?
☐	☐	Do you wear contact lenses?
☐	☐	Have you ever received a blood transfusion?
☐	☐	(Women) Are you pregnant? Due date _____
☐	☐	Do you see a medical specialist for any medical conditions? If yes, type? _____

_____ _____ _____

Signature Printed Name Date

_____

Relation to patient

_____ _____ _____

Anesthesia Provider Signature Printed Name Date

ALL STAR ANESTHESIA

Anesthesia Consent

I (patient or guardian) _____ request and authorize the administration of anesthetic to (patient) _____ while the procedure (name of procedure) Dental Rehab _____ is being performed for (physical condition) Dental Caries _____.

I have been told about the different choices of anesthetics which may be suitable for the physical condition and the type of procedure or surgery being performed. I agree to the anesthetic plan that has been discussed with me.

I also understand that during the procedure or surgery, the physical condition could change, and as a result, the management of anesthesia care might need to be changed. Any necessary changes in the anesthetic plan would be made with the patient's safety as the first concern.

I understand that receiving anesthesia for the procedure or surgery involves risks as well as benefits, and that no promises or guarantees can be made concerning the results of anesthesia medications given during the procedure or surgery. Even minor elective surgery may carry with it a major unforeseen anesthetic risk. Risk and complications may include but not limited to:

- ☐ **General Anesthesia**: sore throat, hoarseness, injury to teeth or mouth, pneumonia or lung injury, awareness under anesthesia, injury to blood vessels, brain damage, loss of life.
- ☐ **Regional Anesthesia**: minor pain or discomfort, intravascular injection, infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels or nerves, adverse drug reactions, loss of life, need for general anesthesia.
- ☑ **Intravenous Sedation**: pneumonia or other lung problems, nerve injury, injury to blood vessels, local irritation to the intravenous site, adverse drug reactions, awareness under anesthesia, brain damage, loss of life, possibility of converting to general anesthesia.

I understand that I may withdraw consent at any time before the anesthetic is given.

I certify that I have read this form, or it was read to me, and that I fully understand it, that I have had the opportunity to ask questions, and the answers and additional information provided have met my satisfaction.

Patient (or Guardian) Signature	Patient (or Guardian) Printed Name	Date	Time

Relation to patient (if applicable)

Anesthesia Provider Signature	Anesthesia Provider Printed Name	Date	Time

Witness Signature	Witness Printed Name	Date	Time