HEALTH EVALUATION

The intention of this questionnaire is to help the dentist and anesthesiologist select the proper dental treatment and anesthetic technique for you. Please do not leave anything blank.

Name of patient _____ Date_____
Address_____
Name of contact _____
Email _____Phone ( )_____Fax ( )_____
CSB _____ Name of Case Manager/Support Coordinator_____
DOB ___/__/____ Weight ____lbs. Height____ft.____in. Sex ____(M/F)
General Health : ___ Excellent ___Good ___Fair ___Poor
Mental Health Diagnosis: _____

Has anyone in your family:	**had a tendency to bleed excessively?**	**___yes**	**___no**
	had unexplained fevers during anesthesia?	**___yes**	**___no**
	had any unusual reactions to anesthesia?	**___yes**	**___no**
Your medical history:	**Do you smoke?**	**___yes**	**___no**
	Do you drink alcoholic beverages?	**___yes**	**___no**
	Have you had a blood transfusion?	**___yes**	**___no**
	Are you pregnant at this time?	**___yes**	**___no**
	Are you allergic to any medications?	**___yes**	**___no**
	If yes, what? _____		
	_____		
Have you had surgery on the:	**brain___, neck___, jaw___, thyroid___, lung___, kidney___**		
	breast___, heart, ___, abdomen___, other_____		

Have you ever had (please check and circle that which applies):

__yes__no	**Heart disease/heart failure/heart attack**	**__yes__no**	**Thyroid disease**
__yes __no	**Heart murmur/rheumatic fever**	**__yes__no**	**Diabetes mellitus**
__yes__no	**Frequent indigestion/hiatal hernia/Gerd**	**__yes__no**	**High blood pressure**
__yes__no	**Palpitations/irregular heart beats**	**__yes__no**	**Blood disorder**
__yes__no	**Abdominal ulcers/obstructions**	**__yes__no**	**Stroke**
__yes__no	**Chest pain/angina/ankle swelling**	**__yes__no**	**Glaucoma**
__yes__no	**Easy bruising/excessive bleeding/hemophilia**	**__yes__no**	**Frequent headaches**
__yes__no	**Abnormal EKG/pacemaker/artificial valve**	**__yes__no**	**Fainting spells**
__yes__no	**Abnormal shortness of breath**	**__yes__no**	**Asthma/wheezing**
__yes__no	**Nerve paralysis/nerve pain/neck pain**	**__yes__no**	**Emphysema**
__yes__no	**Back pain/problems/arthritis**	**__yes__no**	**Bronchitis/pneumonia**
__yes__no	**Phlebitis/DVT/lung blood clots**	**__yes__no**	**Epilepsy/seizures**
__yes__no	**Nervous/ psychiatric/mental health disorder**	**__yes__no**	**Cancer**
__yes__no	**Drug or alcohol addiction**	**__yes__no**	**Tuberculosis**
__yes__no	**Serious illness during pregnancy**	**__yes__no**	**Smoker's cough**

Please continue to complete the back of this form.

__yes__no	Hay fever/seasonal allergies	__yes__no	Motion sickness
__yes__no	Hepatitis/liver disease	__yes__no	Gall bladder disease
__yes__no	Kidney disease	__yes__no	Sickle cell anemia
__yes__no	Other (cold, flu, sleep apnea)	__yes__no	AIDS/HIV

Do you have:

__yes__no	removable dentures	__yes__no	prosthetic eye
__yes__no	contact lenses	__yes__no	loose or chipped front teeth
__yes__no	difficulty opening mouth	__yes__no	porcelain caps on front teeth
__yes__no	difficulty moving head/neck	__yes__no	cataracts
__yes__no	Other physical/congenital defect: _____		

_____

What kind of anesthesia experience have you had before?

__yes__no	Allergies/unusual reaction	__yes__no	General anesthetic
__yes__no	Anesthesia complications	__yes__no	Local or nerve block
__yes__no	Saddle (spinal) block/epidural	__yes__no	Pentothal

_____

MEDICATIONS: Please list names and doses of any medicines you take now or have taken within the last six months (or attach list). Also include herbal medications (St. John's Wort, Ginseng, Gingko Biloba, etc.)

Current medication	Dose	Reason for taking medicine
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Signature of patient or AR/Guardian **Date**