Anesthesia Services Inc
SUPERIOR SAFETY, SUPERIOR SLEEP

(833) 336-8482 or FAX (800) 478-1368

Anesthesia Patient Health Questionnaire

Initial Here_____

Patient's Name: _____DOB: _____ Age: _____

Gender: Male /Female Height:_____ Weight_____lb.

Surgeon/Dentist: _____Date of Surgery: _____

Address:_____ State:_____ Zip Code:_____

Contact Numbers: Home _____ Emergency Contact:_____

E-mail Address: _____

1. List all prescription drugs, over-the-counter medications and herbal supplements that you take:

I do not take medicines or herbal supplements ☐

Name	Dosage	Frequency

2. List all allergies to food, medications and other substances (latex rubber, shellfish, Iodine):

_____

_____

_____

_____

☐ I do not have any known allergies

3. Have you ever had dental or surgical procedures requiring sedation or general anesthesia?

☐ YES ☐ NO

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4. Please list all previous surgeries or dental procedures requiring anesthesia.

Surgical or Dental Procedure Requiring Anesthesia	Year

5. Any difficulties or complications with previous ANESTHESIA or surgery? ☐ YES ☐ NO

Anesthetic Complications	YES	NO
Severe Nausea or Vomiting		
Difficulty waking up		
Awareness while under anesthesia		
Difficult intubation (insertion of breathing tube)		
Malignant hyperthermia (you or your family) -- uncontrolled very high fevers		
Blood relative had major complication		
Other: _____		

6. Have you ever had HEART, CIRCULATION of BLOOD PRESSURE problems? ☐ YES ☐ NO

HEART, CIRCULATION of BLOOD PRESSURE problems?	YES	NO
High blood pressure		
Angina or chest /arm/jaw pain		
High Cholesterol		
Leg or neck artery blockage		
Heart attack		
Congestive heart failure		
Heart murmur/heart valve problem		
Irregular heart beat or palpitations		
Defibrillator		
Born with a heart problem		
Other heart condition _____		

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7. Do you have difficulty climbing two flights of stairs without stopping? ☐ YES ☐ NO

8. Have you ever had a specialized heart test or heart procedure? ☐ YES ☐ NO

Specialized heart test or heart procedure?	YES	NO
Carotid Doppler Study		
Holter monitor		
Stress test		
Heart catheterization		
Echocardiogram		
Cardiac stent? DATE _____		
Heart nuclear scan		
Other test or procedure _____		
Have you been told any of these tests were abnormal?		

9. Have you ever had breathing problems or a lung condition? ☐ YES ☐ NO

Breathing problems or a lung condition?	YES	NO
Asthma		
Emphysema or COPD		
History of pneumonia		
Chronic cough		
Sleep apnea		
Bronchitis		
Recent cold, sore throat (last 2 weeks)		
Use oxygen		
Shortness of breath		
Use CPAP or BiPAP		
Other lung or breathing problems?_____		

10. Have you ever had a brain, nerve, muscle or mental health condition? ☐ YES ☐ NO

Brain, nerve, muscle or mental health condition?	YES	NO
Stroke		
Seizures or epilepsy		
Paralysis		

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Brain, nerve, muscle or mental health condition?	YES	NO
Numbness or weakness		
Multiple sclerosis		
Neuropathy		
Tremors		
Parkinsonism		
Loss of bladder or bowel control		
Muscle disease		
Headache/Migraines		
Anxiety		
Depression		
Other:_____		

11. Have you ever had any liver or digestive problems? ☐ YES ☐ NO

Liver or digestive problems?	YES	NO
Ulcer		
Hiatal Hernia or Acid Reflux Disease (Heart Burn)		
Gallbladder Problems		
Hepatitis		
Yellow Jaundice		
Cirrhosis		
Difficulty Swallowing		
Unintentional Weight Loss		
Other:_____		

12. Have you ever had a kidney or prostate condition? ☐ YES ☐ NO

Kidney or prostate condition?	YES	NO
Chronic Bladder or Kidney Infection		
Kidney Stone		
Diminished Kidney Function/Kidney Failure		
Blood or Peritoneal Dialysis		
Prostate Enlargement or Prostate Cancer		
Other:_____		

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13. Have you ever had blood or clotting disorder? ☐ YES ☐ NO

Blood or clotting disorder?	YES	NO
Anemia		
History of blood transfusion		
Blood clotting disorder		
Sickle cell trait or disease		
Transfusion reaction		
Bruising without reason		
Blood clots in legs or lungs		
Use blood thinners		
Other:_____		

14. Have you had diabetes, thyroid, or endocrine disorder? ☐ YES ☐ NO

Diabetes Treated with:

Diet ☐ Pills ☐ Insulin ☐

Thyroid Disease: High ☐ Low ☐

Prednisone or Steroid Use YES ☐ NO ☐

Other:_____

15. Have you ever had arthritis, spine, joint, or connective tissue problems? ☐ YES ☐ NO

Arthritis, spine, joint, or connective tissue problems?	YES	NO
Degenerative arthritis		
Osteoporosis		
Spine problems: If so, check below.		
Neck		
Upper Back		
Lower Back		
Rheumatoid arthritis		
TMJ/difficulty opening mouth		
Neck stiffness or pain with neck movement		
Fibromyalgia/chronic fatigue		
Fractures		
Other:_____		

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16. For Women:

Date of Last Menstral Period; _____

If pregnant, How many weeks? _____

If pregnant, Who is your OB? _____

17. Did you ever, or do you use tobacco, drink alcohol or use illicit drugs? ☐ YES ☐ NO

Use tobacco, drink alcohol or use illicit drugs?	YES	NO
Cigarette Smoking		
Packs per day _____ Years _____		
Cigar or pipe smoking		
Alcohol: Drinks per day _____		
Treated for alcoholism in the past?		
Marijuana		
Cocaine/Crack		
Methamphetamines		
Other:_____		

18. Have you had an organ transplant of any kind? ☐ YES ☐ NO

Organ transplant of any kind?	YES	NO
Heart		
Lung		
Liver		
Kidney		
Pancreas		
Other:_____		

19. Do you have any of the following implants? ☐ YES ☐ NO

Implants?	YES	NO
Artificial joints		
Pacemaker		
Defibrillator - AICD		
Cardiac Stent		
Vascular Stent		
Medication Pump		
Electrical Stimulator - nerve, diaphragm, brain....		

Continue on to next page until page 8.

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20. Other medical conditions: ☐ YES ☐ NO

Other medical conditions:	YES	NO
Hearing loss		
Vision loss or blindness		
Glaucoma		
Hearing aids		
Contact lenses		
Dental bridge		
Dentures		
Loose teeth		
Capped teeth/veneers		
Dental implants		
Tongue or body piercing		
Do you have a skin condition?		
Other:_____		

21. Have you been hospitalized or been to the ER in the last 12 months? ☐ YES ☐ NO

22. Have you had an EKG in the last 6 months? ☐ YES ☐ NO

23. Have you had a Chest X-ray in the last 12 months? ☐ YES ☐ NO

24. Have you ever been hospitalized over one week? ☐ YES ☐ NO

25. Have you seen someone other than the surgeon in preparation for this dental procedure or surgery? (Internal medicine, Pulmonologist or Cardiologist?) If yes, what is their name and contact information?

Name Phone Last seen

_____ _____ _____

_____ _____ _____

_____ _____ _____

26. Is there anything that needs to be addressed prior to your dental procedure or surgery?

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28. How would you rate your health?

- ☐ Healthy
- ☐ Mild Disease
- ☐ Severe Disease
- ☐ Severe Disease that is a constant treat to life

IF YOU HEALTH IS RATED AT SEVERE DISEASE OR SEVERE DISEASE THAT IS A CONSTANT THREAT TO LIFE, YOU PROCEDURE MAY NOT BE PERFORMED AT THE DENTIST OR DOCTOR OFFICE. YOUR PROCEDURE MUST BE PERFORMED AT AN ACCREDITED HOSPITAL OR AMBULATORY SURGERY CENTER

I HAVE READ AND ANSWERED ABOVE QUESTIONS TRUTHFULLY.

Relation to Patient: Self ☐ Parent ☐ Spouse ☐

Signature: _____ Date: _____

END OF QUESTIONNAIRE

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CONSENT FOR ANESTHESIA SERVICES

Anesthesia Services Inc
SUPERIOR SAFETY, SUPERIOR SLEEP

I,_____ , acknowledge that my doctor has explained to me that I or my child will have an operation, diagnostic, or treatment procedure— medical or dental related. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, my doctor's preference, and my own preference. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ Deep IV Sedation and General Anesthesia (IV= Intravenous)	Expected Result	Total unconscious state, possible placement of a tube into the nose mouth and windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia

☐ Moderate/Conscious IV Sedation (IV= Intravenous)	Expected Result	Total or partial amnesia, reduced anxiety and pain, Intermittent periods of brief unconsciousness Able to follow commands
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	An unconscious state, depressed breathing, injury to blood vessels Partial or total memory of the procedure Advancement to General Anesthesia with associated risks.

☐ I understand that my anesthesia may be advanced to DEEP IV SEDATION and GENERAL ANESTHESIA if Moderate IV Sedation is not effective as determined by my doctor or anesthetist.

☐ I prefer that my anesthesia NOT BE advanced to Deep IV Sedation and General Anesthesia and stopping the procedure IF the procedure being performed safely permits me to be awakened.

Signature_____ Date_____

Guardian Signature_____

G2 Anesthesia HIPAA AUTHORIZATION

I, _____, give permission to G2 Anesthesia to use my protected health information, and/or disclose the my protected health information to:

- Anesthesia Billing Company, Inc.
- List your insurance company or companies:
  _____
  _____
- Your Primary Care provider(s) and/or skilled Nursing Facility Providers.

Information to be disclosed:

- Medical Records
- Dental Records
- Treatment Records
- Diagnostic Records
- Other: (If applicable)_____

This protected health information is being used or disclosed for the following purposes:

- Provider fee reimbursement. (ie. Third party insurance billing)
- Medical or dental consultations related to your treatment and continuity of care.

This authorization expires after one year.

If any person or entity listed above receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to G2 Anesthesia. See our web site for our office address. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____

Signature of Participant or Personal Representative Date

_____

Printed Name of Participant or Personal Representative

_____

Description of Personal Representative's Authority

Anesthesia Services Inc
SUPERIOR SAFETY, SUPERIOR SLEEP

PRE-ANESTHESIA INSTRUCTIONS-- Before coming to the Dentist office:

1. Notify G2 Anesthesia if you have any sudden changes to your health as soon as become aware. This is especially true for even mild colds or flu-like symptoms.
2. Take your regular medications with sips of water as instructed by your Anesthetist.
3. Arrange for transportation for your return home by a responsible friend.
4. Nothing to eat or drink for at least 8 hours before your appointment, except for your regular medications.
5. Urinary incontinence may occur so bring a change of clothing and/or wear an appropriate sized pad or diaper.

POST ANESTHESIA INSTRUCTIONS-- Leaving after your sedation:

1. During your surgery, you will be given an anesthetic to make you comfortable and free of pain. This will be administered either by a fully-trained Certified Registered Nurse Anesthetist (CRNA), dental anesthesiologist (DMD), or physician (M.D.) anesthesiologist.
2. You are required to have a responsible person transport you from the doctor's office after surgery. Someone must stay with you for the next 24 to 48 hours.
3. You may be unaware of the effects of the anesthetic for 24 to 48 hours, even though you may think you feel fine.
4. During this time, you should not engage in any activity that could be harmful to yourself or others, such as driving, smoking in bed, or using power equipment.
5. You should exercise caution and seek assistance when engaging in activities such as walking, climbing stairs, or going to the bathroom. A responsible person should be readily available to assist you with your needs.
6. For some patients undergoing prolonged general anesthesia (more than 3 hours), know that post anesthesia recovery will continue after you arrive home. You will likely need a wheelchair getting to your car and may rely on someone able to provide assistance with strength and balance when you arrive home. We will not discharge you from care unless we are sure that you have recovered sufficiently from anesthesia and your caretaker is appropriate to assist you.
7. You should eat only very light, easily digested foods and liquids for the next 24 hours.

My signature below indicates that I have fully read and understand these post anesthesia instruction and that my anesthesia provider has fully explained any questions that I have regarding my responsibilities related to receiving anesthesia.

_____
Patient Name

_____ Date:_____ Time:_____
Patient Signature