Ambulatory Dental Anesthesia OF MONTANA

[redacted]

MONTANADENTALANESTHESIA.COM

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Patient Health Questionnaire

Chart ID: _____

◆Patient's Name: _____ Sex: __Male __Female Age: ____ Date of Birth: ___/___/___

◆Legal guardian (if dependant adult) _____Relationship:_____

◆Patient's attitude towards dental care: _____

◆Does the patient have special needs? __Yes __ No If so, what? _____

◆Name of Dentist: _____ Dentist's phone number: (_____) _____

◆Name of Physician: _____ Physician's phone number: (_____) _____

◆Height: _____ ◆Weight: _____

◆Are you currently under the care of a physician? __Yes __ No

If yes, please explain reason(s):_____

◆Are you taking any drugs or medications? __Yes __ No

Please list any medications you are currently taking with dose and frequency (may attach copy of medication list if necessary:

Drug	Dose	Frequency	Drug	Dose	Frequency

◆Have you ever been hospitalized, or have previous surgeries? __Yes __ No

If yes, please explain:

Date	Illness/surgery	Duration of hospitalization/complications
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		

◆Have you, or a close relative of yours ever had an adverse reaction to general anesthesia? __Yes __ No

If yes, please explain: _____

◆Following anesthesia, have you ever had nausea or vomiting (i.e. due to drug reaction like with Demerol)? __Yes __ No

◆Are you allergic to latex? __Yes __ No

◆Have you ever experienced itching or a rash after being exposed to latex such as in balloons? __Yes __ No

◆Have you ever experienced an allergic reaction or local sensitivity to bananas, avocados, nuts or kiwi? __Yes __ No

◆Do you have any allergies to medications, drugs, or environmental agents (other than latex)? __Yes __ No

If yes, please list along with reaction that occurs when taking these medications (e.g. swelling, upset stomach, etc..)

Drug	Reaction	Drug	Reaction

◆Please answer the following with yes or no: Have you ever had any of the following conditions?

Yes	No		Yes	No		Yes	No	
_____	_____	Heart attack	_____	_____	Tuberculosis	_____	_____	Anemia
_____	_____	Stent placement	_____	_____	Abnormal chest x-ray	_____	_____	Thyroid disease
_____	_____	Angina	_____	_____	Shortness of breath	_____	_____	Cancer or tumor
_____	_____	Heart murmur	_____	_____	Sleep apnea/snoring	_____	_____	Arthritis
_____	_____	Chest Pain	_____	_____	Liver disease	_____	_____	Artificial joint
_____	_____	Stroke	_____	_____	Hepatitis A, B, C or other	_____	_____	Stroke
_____	_____	High blood pressure	_____	_____	Jaundice	_____	_____	Fainting spells
_____	_____	Heart disease	_____	_____	Kidney disease	_____	_____	Seizure disorder
_____	_____	Congestive Heart Failure (CHF)	_____	_____	Bladder problems	_____	_____	Epilepsy
_____	_____	Chronic bronchitis	_____	_____	Stomach ulcers	_____	_____	Back problems
_____	_____	Emphysema	_____	_____	Acid reflux	_____	_____	Blood clots/DVT's
_____	_____	COPD	_____	_____	Chronic diarrhea	_____	_____	Bleeding tendency
_____	_____	Asthma	_____	_____	Chronic constipation	_____	_____	Psychiatric problems
_____	_____	Hay fever	_____	_____	GERD	_____	_____	Motion sickness
_____	_____	Sinus trouble	_____	_____	Diabetes	_____	_____	Transient ischemic attack/TIA

◆Please explain anything marked "yes" above in the space provided:

_____

_____

_____

_____

◆Do you smoke? __Yes __ No

If yes, how many packs a day do you smoke? _____ packs per day

For how many years have you smoked this many packs a day? _____years

◆Do you drink alcohol? __Yes __ No

If yes, what do you drink? _____

How frequently, and how many do you drink? _____

◆Do you take recreational drugs such as marijuana, cocaine, crystal meth, ecstasy, or others? __Yes __ No

If yes, what do you take? _____

If yes, when was the last time you took any recreational drugs? _____

The above information is, to the best of my understanding current and accurate regarding myself or dependant person whom I am legally empowered to make health care decisions for. I understand that the anesthesia plan for this individual is heavily based on this document, and its contents vital to my or their health.

Signed: _____ Date: ____/_____/____

Signed: _____ Date: ____/_____/____

Terry Klise, DDS