ETOBICOKE PERIODONTICS & IMPLANY CLINIC

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 disorder			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 disorder		
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 problem		
Heart rhythm disorder			Lung disease			Stroke		
Heart surgery			Malignant hyperthermia			Temperature tolerance		
Hemophilia			Medical implant			Thyroid disease		
Hepatitis A			Mental/nervous disorder			Tuberculosis		
Hepatitis B			Mitral valve prolapses			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(hype) glycemia			Positive testing for HIV					

Do you smoke or use other forms of tobacco? ☐Yes ☐No If yes, please explain. _____

Do you have a history of alcohol and/or drug use? ☐Yes ☐No If yes, please explain. _____

Have you received treatment for alcohol or drug use? ☐Yes ☐No If yes, please explain. _____

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 If yes, please explain. _____

WOMEN ONLY:

Are you pregnant or suspect you might be? ☐ Yes ☐ No If yes, please explain. _____

Are you breast feeding? ☐ Yes ☐ No If yes, please explain. _____

Are you taking any birth control pills? ☐ Yes ☐ No If yes, please explain. _____

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR OFFICE HEALTH STATUS BE REPORTED TO YOUR 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 in information that is required for my dental care.

DATE:

PATIENT NAME:

SIGNATURE

CONSENT FOR DENTAL TREATMENT AND MINIMAL, MODERATE or DEEP SEDATION

PROCEDURE(S)

_____

_____

_____

OPERATING DENTIST

_____

PRACTITIONER ADMINISTERING SEDATION

_____

I, the undersigned, hereby consent to the procedure(s) noted above. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives including not having any treatment. I understand that the proceed minimal/moderate sedation and I consent to the administration of this by the above-named practitioner administering the minimal or moderate sedation. I also understand that during the course of any treatment, unforeseen circumstances may arise that make it advisable for an additional or alternate procedure to be performed, which I also consent to being performed on me.

DATE:

PATIENT NAME:

SIGNATURE

I acknowledge receiving a copy of the pre- and post-operative instructions which have been explained to me. I understand all the advice given to me by my dentist. After my discharge, I will notify dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems.

DATE:

PATIENT NAME:

SIGNATURE

PRE IV SEDATION ASSESSMENT

Name: _____Date of Assessment: _____

Age and gender: _____Occupation: _____

Pregnancy: _____

Allergies: _____

Neurological system: _____

Renal dysfunction: _____

Adrenal insufficiency: _____

Glaucoma: _____

Pulmonary system: _____

Sleep apnea: _____

Malign hyperthermia: _____

Cardio-vascular disease: _____

GI system: _____

Prescribed Rx: _____

Over the counter meds and supplements: _____

Tobacco: _____

Narcotic and drug used: _____

Alcohol: _____

Mallampati classification (tongue completely out): _____

Obesity and body type:

- Height: _____
- Weight: _____
- BMI: _____

Others: _____

ASA: _____

Cost Estimate: _____Procedure: _____

Consent to IV sedation understood and signed:

Preop instructions given verbally and written:

No solid food or gum chewing or fluids for 6 hrs prior to surgery	
No clear fluids 3 hrs prior to surgery	
Must be escorted day of surgery (legally impaired for 24 hrs)	
Procedures and length of procedures	
Patient understand procedures	

Postop instructions given verbally and written

DATE:

PATIENT NAME:

SIGNATURE

PRE-SEDATION PATIENT INSTRUCTIONS

For the safe treatment of the patient, the following pre-sedation instructions must be followed very carefully.

FOOD AND BEVERAGES

- It is essential that the stomach be empty at the time of the sedation appointment
- Do not eat any solid foods or drink full fluids within six hours of the sedation appointment.
- Do not drink anything, even water for at least 3 hours before the sedation appointment.
    - **Do not drink any alcohol prior to treatment

MEDICATIONS

- It is essential to discuss with your dentist whether or not you should take medication(s) you otherwise take on a regular basis

CLOTHING/CONTACT LENSES

- Wear loose casual clothing for the appointment (e.g. short sleeve tee shirt). Female patients

should wear pants

- Do not wear contacts on the day of your appointment

SMOKING

- Refrain from smoking prior to treatment

TRANSPORTATION

- Under no conditions can you drive yourself home. A responsible adult (excluding ataxicab driver) must pick you up after the appointment and accompany you home.
    - *Public transportation is not recommended

CHANGE IN HEALTH STATUS

- If your general health deteriorates (e.g. cold, cough, fever etc.) or changes, contact your resident prior to the day of the appointment.

If you have any questions, please do not hesitate to ask them. It is important that you understandthese instructions.