anesthesia for dentistry

Mai-Phuong Huynh, DDS, FADSA
4488 Convoy Street, Suite G
San Diego, CA 92111
(619) 339-1188
maidentalanesthesia@gmail.com

Medical History Form

Name_____ Home Phone (_____)_____
Last First Middle

Address_____ Work Phone (_____)_____

City_____ State _____ Zip_____ Cell Phone (_____)_____

Date of Birth ____/____/_____ Sex: M F Best # to reach you _____

Closest Relative _____ Phone (_____)_____

Who is your Dentist? _____

Who is your Doctor? _____ Phone (_____)_____

Date of last physical exam _____/_____/_____ Height_____ Weight_____

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Please list all medications with dosages you are now taking (include vitamins, laxatives, and birth control pills):

_____

_____

_____

Do you have any allergies? No Yes Drugs_____
No Yes Foods_____
No Yes Other_____

For the following questions, please circle Yes or No. Your answers will be considered confidential.

1. Are you in good health?..... Yes No
2. Have you had any serious illness, operation, or been hospitalized in the last 5 years?..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment?..... Yes No
   If so, explain_____
4. Have you had any unexpected problems with anesthesia?..... Yes No
5. Has any member of your family had any unexpected problems with anesthesia?..... Yes No
6. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including murmur or rheumatic heart disease Yes No
   b. Cardiovascular disease
      Heart trouble, heart attack, angina (chest pain), coronary occlusion…… Yes No
      High blood pressure…….. Yes No
      Arteriosclerosis…… Yes No
      Stroke…… Yes No
      Cardiac dysrrythmia or arrhythmia…… Yes No

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1. Do you have any chest pain upon exertion?..... Yes No
2. Are you ever short of breath after mild exercise, or lying down?..... Yes No
3. Do your ankles swell?..... Yes No
4. Do you have a cardiac pacemaker?..... Yes No

c. Respiratory disease

Chronic cough…… Yes No
Emphysema, pneumonia, bronchitis, tuberculosis (TB)…… Yes No
Asthma, sinus trouble, or hay fever…….. Yes No
1. Do you smoke? Packs per day_____ How many years?_____..... Yes No
2. Do you currently have a cold or flu?..... Yes No

d. Continuous Positive Airway Pressure (CPAP) use…….... Yes No

Type of Mask use_____

Women:

7. Are you now or is there any possibility that you are pregnant?..... Yes No
8. Are you nursing?..... Yes No
9. Do you have any problems associated with your menstrual period?..... Yes No

10. Please **circle** any of the following which you have had or have at present:

Anemia	Kidney trouble	Ulcers or heartburn (gastric reflux)
Diabetes	Thyroid disease	Radiation treatment
Chemotherapy	Arthritis	Rheumatism
Cortisone medicine	Glaucoma	Pain in joints
AIDS (HIV)	Hepatitis	Liver disease
Yellow jaundice	Blood transfusion	Hemophilia
Venereal disease	Cold sores	Epilepsy, Seizures
Fainting or dizzy spells	Nervousness	Mental retardation
Sickle cell disease	Renal dialysis	Physical handicap
Persistent diarrhea	Low blood pressure	Cancer, type_____

11. Do you have any disease, condition, or problem not listed above?..... Yes No
If yes, explain_____
12. Do you now, or have you ever taken any recreational drugs?..... Yes No
If so, list drugs(s)_____
13. Do you drink alcohol? If so, how much per day_____ Yes No
14. Are you wearing contact lenses?..... Yes No

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health, or if my medicines change,
I will inform my anesthesiologist at the earliest possible time.

_____
Signature of Patient or Guardian

_____
Date