ELITE SEDATION

PATIENT HEALTH HISTORY

Name: _____ **Birth Date:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home/Cell Phone: _____ **Email:** _____

Emergency contact: _____ **Phone:** _____

Medical History

1. Height: _____ Weight: _____
2. Is the patient currently under the care of a physician for a specific condition? _____ ☐ Yes ☐ No
3. Date of last physical exam? _____
4. Date of last cold, cough or fever? _____
5. Physician: _____ Phone Number: _____
6. Please describe patient's current physical health: ☐ Excellent ☐ Good ☐ Poor
7. Please describe patient's routine physical activity: _____
8. Does the patient experience shortness of breath? ☐ At rest ☐ minimal exertion ☐ moderate exertion
9. Has there been any changes in health in the last year? _____ ☐ Yes ☐ No
10. Has the patient had any recent hospitalizations or surgeries? _____ ☐ Yes ☐ No
    a. If yes, when and why _____
11. Does the patient have cardiovascular disease? _____ ☐ Yes ☐ No
    a. If yes, circle- arrhythmia, chest pain, coronary artery disease, heart attack, heart failure, heart valve disease/replacement, hypertension, pacemaker/defibrillator, stents
    Other _____
12. Does the patient have pulmonary disease or symptoms? _____ ☐ Yes ☐ No
    a. If yes, circle- asthma, bronchitis, emphysema, persistent cough, tuberculosis, wheezing
    Other _____
13. Has the patient ever been diagnosed with sleep apnea? _____ ☐ Yes ☐ No
14. Has the patient ever had any of the following medical problems?

☐ Arthritis
☐ Bleeding Problems / Bruise easily
☐ Blood disorder
☐ Cancer
☐ Diabetes
☐ Fainting episodes
☐ Hepatitis / Liver problems
☐ Kidney Problems
☐ Muscle weakness
☐ Seizures / Epilepsy
☐ Stroke
☐ Other _____

15. Please list all medications the patient is currently taking: _____
_____
16. Please list all allergies to medication or food: _____

Elite Sedation
Dr. Andrew Elmasri - Dr. Albert Kang - Dr. Charles Lee
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T: (949)529-9289 - F: (949)606-8590

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PATIENT HEALTH HISTORY

**** Questions 17 – 23 are for adults and teens only ****

17. Do you smoke? If yes- how long? Packs/day?_____ ☐ Yes ☐ No
18. Do you drink alcohol? If yes, how much?_____ ☐ Yes ☐ No
19. Do you use recreational drugs? If so, what drug and when?_____ ☐ Yes ☐ No
20. Have you or a close relative ever had a bad reaction to any anesthetic drug?_____ ☐ Yes ☐ No
21. Have you ever had complications during a previous anesthetic?_____ ☐ Yes ☐ No
22. What is your anxiety level related to dental treatment? ☐ Mild ☐ Moderate ☐ Severe
23. WOMEN: Is there any possibility that you could be pregnant?_____ ☐ Yes ☐ No

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform the anesthesiologist of any changes in my medical status at the earliest possible time.

Signature of Patient: _____ **Date:**_____

Reviewed by:_____ **Date:**_____

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