737
SEYMOUR DENTAL

Dr. Natalee Peeters
Dr. Dustin Wurm
Dr. Kristopher Bouwmeester

Pre-Sedation Record

Date: _____

Name: _____

Date of Birth: D____/M____/Y____ Gender:_____

Phone: Res_____ Cell:_____

Address: _____

Person to notify in case of emergency: _____Phone:_____

If applicable, name of parent or legally authorized representative: _____

Medical History Questionnaire

Have you ever had a minimal or moderate sedation? □No □Yes

If yes, when? _____

Any complications? □No □Yes

If yes, please explain: _____

Any history of familial sedation/anesthetic complications? □No □Yes

If yes, please explain: _____

Are you being treated for any medical condition at present or within the past two years? □No □Yes

If yes, please explain: _____

When was your last visit to a physician? _____Last complete medical exam?_____

Have you ever had a serious illness, accident, or required extensive medical care? □No □Yes

If yes, please explain: _____

Have you been hospitalized in the last five years? □No □Yes

If yes, please explain: _____

Are you taking any prescription or non-prescription drugs? □No □Yes

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?

□No □Yes If yes, please explain_____

Do you have any sensitivities or allergies? □No □Yes

If yes, please explain _____

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Do you have any history of family disease? □No □Yes

If yes, please explain _____

Have you ever taken medication for Osteoporosis? □No □Yes

If yes, □ Oral Medication □ IV Medication □ Shots Last dose in (years) _____

Have you ever taken bisphosphonate medication? □No □Yes

Indicate which of the following you presently have or ever had:

	Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Bleed easily	☐	☐	Congenital heart lesions	☐	☐
Alzheimer's	☐	☐	Blood disorders	☐	☐	Congestive heart failure	☐	☐
Anemia	☐	☐	Blood in sputum	☐	☐	Cortisone/steroid therapy	☐	☐
Angine pectoris	☐	☐	Bronchitis	☐	☐	Diabetes	☐	☐
Arthritis/rheumatism	☐	☐	Cancer	☐	☐	Earaches (frequent)	☐	☐
Artifical heart valve	☐	☐	Cerebral palsy	☐	☐	Emphysema	☐	☐
Artifical joints	☐	☐	Changes in appetite	☐	☐	Epilepsy or seizures	☐	☐
Asthma	☐	☐	Chest pains	☐	☐	Fainting or dizzy spells	☐	☐
Balance problems	☐	☐	Circulation problems	☐	☐	Glandular disorders	☐	☐
Glaucoma	☐	☐	Hypertension	☐	☐	Psychiatric treatment	☐	☐
Headaches (severe)	☐	☐	Impaired vision	☐	☐	Radiation treament/		
Head/neck injuries	☐	☐	Infective endorcaditis	☐	☐	chemotherapy	☐	☐
Hearing difficulties	☐	☐	Jaundice	☐	☐	Rheumatic/scarlet fever	☐	☐
Heart disease or attack	☐	☐	Kidney disease	☐	☐	Shortness of breath	☐	☐
Heart murmur	☐	☐	Leukemia	☐	☐	Sickle cell disease	☐	☐
Heart pacemaker	☐	☐	Liver disease	☐	☐	Sinus Trouble	☐	☐
Heart rhythm disorder	☐	☐	Lung disease	☐	☐	Stomach/intestinal problem	☐	☐
Heart surgery	☐	☐	Malignant hyperthermia	☐	☐	Stroke	☐	☐
Hemophilla	☐	☐	Medical Implant	☐	☐	Temperature intolerance	☐	☐
Hepatitis A	☐	☐	Mental/nervous disorder	☐	☐	Thyroid disease	☐	☐
Hepatitis B	☐	☐	Mitral valve prolapse	☐	☐	Tuberculosis	☐	☐
Hepatitis C	☐	☐	Nosebleeds (frequent)	☐	☐	Ulcers	☐	☐
Herpes	☐	☐	Organ transplant	☐	☐	Venereal disease	☐	☐
High/low blood presure	☐	☐	Persistant cough	☐	☐	Weight gain/loss	☐	☐
Hodgkin's disease	☐	☐	Pulmonary edema	☐	☐	Osteoporosis	☐	☐
Hyper(hypo) glycemia	☐	☐	Positive testing for HIV	☐	☐	Other _____	☐	☐

Do you smoke or use other forms of tobacco? □No □Yes _____

Do you have a history of alcohol and/or drug use? □No □Yes

If yes, please explain: _____

Have you received treatment for alcohol or drug use? □No □Yes

If yes, please explain: _____

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Do you currently have, or have you had in the past, any disease, condition or problem not list?

□No □Yes If yes, please explain _____

Is there any problem or medical condition that you wish to discuss in private only? □No □Yes

WOMEN ONLY: Are you pregnant or suspect you might be? □No □Yes

Anticipated delivery date? _____

Are you breast feeding? □No □Yes _____

Are you taking any birth control pills? □No □Yes_____

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

Signature _____Date _____

□Patient □Parent □Legally Authorized Representative

Reviewed by dentist _____Date _____