LEVEL UP
ANESTHESIA

HEALTH INFORMATION FORM

HEALTH HISTORY ---- PLEASE COMPLETE USING ONLY BLACK OR DARK BLUE INK

Please complete truthfully and to the best of your knowledge. These questions and replies assure you are provided the safest anesthetic as possible for your procedure. Please fax the completed form to the above number or return to your Doctor or Dentist's Office as soon as possible. The requested contact information is also for the purpose of providing the safest anesthetic by communicating with you.

Patient Name _____ Age _____ Date of Birth: _____ Sex: M | F
(Mr. Mrs. Ms. Dr) First MI Last Mo/Day/Yr

Last 4 digits of Patient Social Security Number: _____ Height _____ Weight (lbs) _____

Address _____
Number & Street City State Zip Code

Home# _____Work# _____ Cell#_____ Fax# _____

Email: _____ Occupation _____

Best time to contact you: _____ Preferred method of contact: _____

Name of Spouse or Guardian & Number_____

Name of Closest Relative _____ Relationship: _____Phone# _____

Date of Procedure: _____Physician/Dentist Name:_____

Planned Procedure: _____

If you are completing this form for the patient, what is your relationship? _____

Patient history of anesthesia complications? No Yes:_____

Family history of anesthesia complications? No Yes: _____

Allergies: __None Latex Tapes/Adhesives Foods Medications List all allergies:
_____
_____

MEDICATIONS: List ALL Prescription & Non Prescription

_____
_____
_____

SURGERIES: List ALL previous

_____
_____
_____

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Please place an "X" next to any "yes" answers. (Your answers will remain strictly confidential and will only be used for the purpose of administering a safe anesthetic to you.)

___ Pregnant or possibly pregnant?
___ Allergies to Medications
___ Anesthesia Complications/Reactions
___ High Blood Pressure
___ Heart Problems
___ Congestive Heart Failure
___ Heart Murmur
___ Irregular Heart Beat/Rhythm
___ Heart Valve problems:
___ Poor blood circulation
___ Atherosclerosis (hardening of the arteries)
___ Heart Attack
___ Chest Pain (Angina)
___ Use nitroglycerin pills or spray
___ Heart Blockages
___ Pacemaker / Defibrillator
___ Seasonal allergies
___ Asthma, bronchitis
___ COPD, emphysema
___ Shortness of breath with mild exertion
___ Sleep Apnea Use CPAP? Yes / No
___ Smoke: How much?
___ Reactive Airway Disease
___ Sinusitis
___ Seizures
___ Stroke: Impairments
___ "mini strokes" TIA
___ Fainting spells
___ Depression, Anxiety, Panic Attacks
___ Motion sickness
___ Drink Alcohol: How much?
___ User of cocaine, speed, marijuana, etc.
___ Premature birth? How many week

Special needs:

___ Autism ADHD/ADD Learning Disorders

___ Hepatitis: A B C
___ Liver disease: ___
___ Diabetes: Type I II
___ Thyroid Disease:
___ Kidney Disease:
___ Kidney Failure / Insufficiency
___ Ulcer Irritable Bowel Ulcerative Colitis
___ Heartburn Reflux Disease
___ Hiatal Hernia
___ Arthritis: osteo rheumatoid
___ Long term steroid prescription
___ Migraine headaches
___ Muscular Disorders: Please specify diagnosis below:
___Muscular Dystrophies
___ Back or Neck problems
___ HIV AIDS
___ Immune Disorders
___ Bleeding Disorders
___ Anemia
___ Sickle Cell: Disease / Trait
___ Cancer Type: _____
___ Chemotherapy
___ Radiation Therapy
___ Motion Sickness
___ Syphilis, gonorrhea, herpes, etc.
___ Steroid medications use
___ Tuberculosis
___ Eye disease
___ Bleed or bruise easily
___ Use diet pills (prescription or non-prescription)
___ Do you live with smokers?
___ Snore?
___ Daytime sleepiness
___ Claustrophobia

___ Had any cold symptoms such as cough, fever, sore throat, nasal congestion, chills in the last two weeks?
___ Pregnant or possibly pregnant? ___ ___ Date of Last menstrual period?
___ Nursing mother?
___ Other health issues not mentioned here? ___ Immunizations up to date?
Explain:_____
Do you consider yourself in good health? Yes / No

***What diagnosis/symptoms do you have that require this dental treatment/MRI/PET/CT Scan/procedure/surgery?

_____
_____
_____

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed this history carefully and have answered all questions truthfully and to the best of my knowledge.

_____ _____
SIGNATURE OF PATIENT (OR GUARDIAN) DATE