BAY ANESTHESIA GROUP

Phone (650) 282-4171
Fax (650) 282-4187
info@bayanesthesiagroup.com
www.bayanesthesiagroup.com

Medical History for Adult Patients

Patient Name: _____ Date: _____

Name of Dentist/Office:_____ Appointment Date: _____

Name of person completing form:_____ Relationship to patient:_____

Phone: _____ Text OK? YES ☐ NO ☐ Email: _____

Mailing Address:_____

Date of Birth:_____ Sex: MALE ☐ FEMALE ☐ Other ☐

Height: _____feet _____inches Weight: _____lbs. Date of Last Physical:_____

Primary Physician: _____ Phone:_____

Group/Practice:_____ City:_____

Specialist Physician:_____ Phone:_____

Group/Practice:_____ City:_____

Previous and Current Health History: Please provide complete and accurate information.

1. Have you ever had surgery? NO ☐ YES ☐

Type of surgery and date : _____

2. Do you bleed excessively after a cut or surgery? NO ☐ YES ☐

Explain: _____

3. Have you ever had general anesthesia? NO ☐ YES ☐

Were there any complications with the anesthesia? _____

4. Do you have any allergies to drugs, supplements or latex? NO ☐ YES ☐

Type of allergy: _____

Reactions: RASH ☐ HIVES ☐ EMERGENCY ROOM ☐ OTHER ☐ Explain: _____

Family History

5. Has anyone in your family had complications with general anesthesia? NO ☐ YES ☐

Explain: _____

6. Has anyone in your family had a history of malignant hyperthermia during surgery? NO ☐ YES ☐

Explain: _____

7. Do you have a DNR/DNI in place? NO ☐ YES ☐

Medications

List all medications, drugs and supplements you are currently taking taking: _____

_____

Women Only:

Are you currently pregnant or is there a possibility that you may be? NO ☐ YES ☐
Are you currently nursing? NO ☐ YES ☐
When was your last menstrual cycle? _____

Have you ever been diagnosed with, treated for, or are currently experiencing any of the following conditions?

Condition	Yes	No	If Yes, Please Provide Further Details
Heart Murmur	☐	☐	
High Blood Pressure	☐	☐	
Irregular Heart Beat	☐	☐	
Congenital Heart Defect	☐	☐	
Heart Surgery	☐	☐	
Chest Pain	☐	☐	
Heart Attack	☐	☐	
Other Heart Problems	☐	☐	
Shortness of Breath	☐	☐	
Asthma	☐	☐	

Patient Name: _____

Condition	Yes	No	If Yes, Please Provide Further Details
Emphysema/Bronchitis/COPD	☐	☐	
Obstructive Sleep Apnea	☐	☐	
Current or Past Smoker (Vape, Marijuana, Cigarettes)	☐	☐	
Other Lung Problem	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Liver Disease/Hepatitis	☐	☐	
Gerd/Ulcer/Acid Reflux	☐	☐	
Stroke	☐	☐	
Recurrent Nose Bleeds	☐	☐	
Bleeding/Clotting Disorder	☐	☐	
Anemia	☐	☐	
Seizure Disorder	☐	☐	
Genetic Syndrome	☐	☐	
Down Syndrome	☐	☐	
Autism Spectrum	☐	☐	
Psychiatric Condition	☐	☐	
Recreational Drug Use	☐	☐	
Cancer	☐	☐	
Thyroid Problems	☐	☐	
Osteoporosis	☐	☐	
Muscle/Joint Problems	☐	☐	

Please specify any additional medical conditions or symptoms that are not mentioned above:

_____

_____

Patient Name: _____

I hereby certify that the information provided above is complete and accurate to the best of my knowledge. I acknowledge that any incomplete or inaccurate information may adversely affect my treatment and its outcomes. Additionally, I authorize Bay Anesthesia Group to communicate patient information using the contact details provided.

_____

Patient Signature or Legal Guardian's Signature (If completed on behalf of the Patient) Date

_____

Legal Guardian's Name Printed (If completed on behalf of the Patient)

Patient Name: _____

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THE CARE YOU NEED, WHERE YOU NEED IT

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Consent for Anesthesia Services

The following is provided to inform patients and parents about having treatment under anesthesia. The information is not presented to make you more apprehensive, but rather to enable you to better understand the risks and benefits involved with anesthetic treatment.

I hereby authorize and request any Dentist Anesthesiologist represented with Bay Anesthesia Group to administer anesthesia as previously discussed with me. I understand and agree that procedures not talked about, but deemed necessary for myself/my child's well-being, may be performed to supplement the planned anesthesia. It has been explained to me that all types of anesthesia, although safe, involve some risks and no guarantees can be made concerning results. Serious complications are very rare. The following are complications that may be associated with the anesthetic treatment:

Common complications:

- Pain and/or bruising at the IV site
- Sore throat and/or hoarseness
- Muscle aches
- Nausea and/or vomiting

Uncommon complications:

- Headache
- Injuries to lips or teeth from airway instruments or devices
- Unexpected drug reaction
- Infection at intravenous site and veins nearby
- Bleeding/injury in the nose due to passage of a breathing tube
- Lung infection
- Eye injury or infection
- Weakness in breathing after awakening
- Nerve damage

Rare complications:

- Heart injury
- Brain damage or death

The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your/your child's anesthesia for dental treatment, and consult with your dentist or physician as needed.

Patient Name: _____

Alternative options to deep sedation/general anesthesia have been discussed with me and may include the use of local anesthesia with nitrous oxide sedation or local anesthesia alone.

All sedation and anesthesia patients must be accompanied to and from the appointment by a responsible adult. The responsible adult should remain in the office during the appointment unless authorized by the practitioner. For the safety of the patient, the responsible adult must remain in the designated waiting area during treatment time. Office staff will escort the responsible adult back to the treatment area once the anesthesiologist deems it is safe, to be present for recovery. Upon release, the patient must be driven home by the responsible adult (public transportation or cabs are not acceptable).

I confirm that myself/the patient has not had anything to eat (other than indicated medications with water) for at least seven (7) hours prior to anesthesia, and only clear fluids were consumed up to two (2) hours prior to anesthesia.

I certify that to the best of my knowledge, myself/the patient is not pregnant or trying to become pregnant.

I have read and agreed to the Notice of Privacy Practices/HIPAA agreement posted on our website www.bayanesthesiagroup.com.

I consent to the anesthesia deemed appropriate by my Dentist Anesthesiologist. I acknowledge that I have read this form or had it read to me and that I understand the risks, alternatives and expected results of the anesthetic plan of care.

_____

Patient Signature or Legal Guardian's Signature (If completed on behalf of the Patient) Date

_____

Legal Guardian's Name Printed (If completed on behalf of the Patient)

_____

Legal Guardian Relationship to Patient

Patient Name: _____