BELLEFONTE FAMILY DENTISTRY

MEDICAL HISTORY FOR SEDATION PATIENTS

Name:_____ Date:_____

Current Weight: _____
Current Height:_____

Name of person picking you up from your appointment:_____

Phone number of person picking you up from your appointment:_____

1. Are you now under a physician's care or have you been during the past 5 years, including hospitalizations(s) and surgery?

   _____
   _____
   _____

2. Are you currently under a doctor's orders or taking any medication(s), including any birth control pills (BCPs), over-the-counter drugs, or homeopathic preparations?

   _____
   _____
   _____

3. Do you have any allergies or are you sensitive to any drugs or substances such as penicillin, Novocain, aspirin, latex, codeine, eggs or soybeans?

   _____
   _____
   _____

4. Have you ever bled excessively after a cut, sound, or surgery? Have you ever received a blood transfusion?

   _____
   _____
   _____

5. Are you subject to fainting, dizziness, nervous disorders, seizures, or epilepsy? Do you have sleep apnea?

   _____
   _____

6. Have you ever had any breathing difficulty, including asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorders? Do you use any tobacco products?

7. Have you or your family members ever had any anesthesia-related problems?

8. Do you have heart disease or a history of chest pain or palpations?

9. Is there anything you would like to discuss alone with the doctor?

10. Do you currently use or have a history of using recreational drugs?

Signature of Patient, Parent or Guardian **Date**

For Doctor's Use Only – Core Physical Exam
General Appearance –
Head and Neck –
Intraoral –
Cardiovascular –
Pulmonary –
Neurologic –

Signature of Doctor: Date