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

_____ _____