SAFE SLEEP
ANESTHESIA PARTNERS

Patient's Name:_____Date of Birth: _____/_____/_____ Age: _____ Weight: _____lb

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (___ ___)_____ ❑Male ❑ Female

Date of Scheduled Treatment: _____/_____/_____ Dentist/Surgeon's Name: _____

Have you had a cold, cough or fever in the last two weeks? ❑Yes ❑ No Explain_____
Have you ever been hospitalized or had a major operation? ❑Yes ❑ No Explain_____
Have you ever had a serious head or neck injury? ❑Yes ❑ No Explain_____
Have you or any relatives had complications with anesthesia? ❑Yes ❑ No Explain_____
Do you have Asthma or other respiratory problems? ❑Yes ❑ No Explain_____
Have you taken any prescription or over-the-counter medications including herbals or steroids? ❑Yes ❑ No Explain_____
Do you use tobacco or exposed to second hand smoke? ❑Yes ❑ No Explain_____
Have you taken any illegal substances or recreational drugs? ❑Yes ❑ No Explain_____
Do you have an Advance Directive? ❑Yes ❑ No Explain_____

Are you allergic to ANY medications, foods, latex, etc.? Please list and explain reaction._____

_____

Do you have, or have you had, any of the following? If you mark "yes" to any of the following, please explain in comment section below.

Are you currently under the care of a physician? ❑Yes ❑ No

Aids/HIV Positive	❑Yes ❑ No	Chromosomal Abnormality	❑Yes ❑ No	High Cholesterol	❑Yes ❑ No
Acid Reflux/Stomach Problems	❑Yes ❑ No	Cold sores/Fever blisters	❑Yes ❑ No	Kidney Problems	❑Yes ❑ No
Anaphylactic Reaction	❑Yes ❑ No	Developmental Delay	❑Yes ❑ No	Liver Problems	❑Yes ❑ No
Bleeds or Bruises Easily	❑Yes ❑ No	Diabetes/Hypoglycemia	❑Yes ❑ No	Neurologic: Seizures/Migraines	❑Yes ❑ No
Bone/Joint Problems	❑Yes ❑ No	Eczema/Rash/Hives	❑Yes ❑ No	Psychiatric Issues/Excessive fears	❑Yes ❑ No
Cancer	❑Yes ❑ No	Hepatitis A,B, or C	❑Yes ❑ No	Premature birth	❑Yes ❑ No
Chest Pain/Heart Problems	❑Yes ❑ No	Heart Disease	❑Yes ❑ No	Thyroid Disease	❑Yes ❑ No
Disabilities or Restrictions	❑Yes ❑ No	High Blood Pressure	❑Yes ❑ No	Tuberculosis	❑Yes ❑ No
Lung Disease	❑Yes ❑ No	Snoring/Sleep Apnea	❑Yes ❑ No	Large Tonsils	❑Yes ❑ No
Loose/Cracked/Chipped teeth	❑Yes ❑ No	Dentures/Dental appliances	❑Yes ❑ No	Glasses/Contact Lenses	❑Yes ❑ No

Have you ever had any serious illness not listed above? ❑Yes ❑ No

Comments:_____

_____

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge. I hereby give permission to Summit Anesthsia to discuss my medical health with other health professionals involved with my care.

It is my responsibility to inform the doctor's office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____

Relationship to Patient:_____ DATE:_____