McCARTY ANESTHESIOLOGY
PATRICK D.McCARTY, D.D.S
DENTIST ANESTHESIOLOGIST
SEDATION AND GENERAL ANESTHESIA FOR DENTAL PATIENTS

| DENTIST: | DATE / / |
|---|---|

| PATIENT NAME (FIRST, MIDDLE, LAST) | AGE | DATE OF BIRTH |
|---|---|---|
| STREET ADDRESS | | SEX ☐ MALE ☐ FEMALE |
| (CITY, STATE & ZIP) | | HOME PHONE |
| SOCIAL SECURITY # E-MAIL ADDRESS | | CELL PHONE |
| EMERGENCY CONTACT | | EMERGENCY CONTACT PHONE |

WHO ARE YOU COMPLETING THIS FORM FOR?
☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

NAME OF PHYSICIAN PHONE # FAX #

| CHANGE IN YOUR HEALTH IN LAST YEAR? Yes No | HOSPITALIZATION IN LAST 5 YEARS? Yes No | CURRENTLY TAKING MEDICATIONS? Yes No |
|---|---|---|
| **ALLERGIES TO MEDICATION?** | **ALLERGIES TO FOOD?** | **ALLERGIES TO OTHER SUBSTANCES?** |

## PLEASE LIST ALL MEDICATIONS & DOSAGE CURRENTLY TAKEN:

| | | |
|---|---|---|
| 1 | 4 | 7 |
| 2 | 5 | 8 |
| 3 | 6 | 9 |

## PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE CHECK IF YOU (PATIENT) HAVE HAD PROBLEMS WITH OR ARE PRESENTLY EXPERIENCING OF ANY OF THE FOLLOWING

- ☐ 1. WEIGHT _____ LBS
- ☐ 2. HEIGHT _____' _____ ' '
- ☐ 3. CANCER
- ☐ 4. HEART DISEASE
- ☐ 5. CHEST PAIN / CHEST TIGHTNESS
- ☐ 6. HIGH BLOOD PRESSURE
- ☐ 7. SWOLLEN ANKLES
- ☐ 8. PALPITATIONS
- ☐ 9. LIGHTHEADEDNESS
- ☐ 10. DAMAGED HEART VALVES
- ☐ 11. ARTIFICIAL VALVES, JOINTS OR ARTERIES
- ☐ 12. HEART MURMUR
- ☐ 13. PACEMAKER
- ☐ 14. IRREGULAR HEARTBEAT
- ☐ 15. SNORING
- ☐ 16. OBSTRUCTIVE SLEEP APNEA
- ☐ 17. NECK STIFFNESS
- ☐ 18. SHORTNESS OF BREATH
- ☐ 19. PNEUMONIA
- ☐ 20. PERSISTENT COUGH
- ☐ 21. T.B.
- ☐ 22. HAY FEVER
- ☐ 23. BRONCHITIS
- ☐ 24. ASTHMA
- ☐ 25. COPD
- ☐ 26. EMPHYSEMA
- ☐ 27. CHRONIC COUGH
- ☐ 28. COLITIS
- ☐ 29. NAUSEA
- ☐ 30. ULCERS
- ☐ 31. REFLUX
- ☐ 32. WEAKNESS
- ☐ 33. SMOKING
- ☐ 34. STROKE
- ☐ 35. DIFFICULTY SWALLOWING
- ☐ 36. ARTHRITIS
- ☐ 37. UNEXPLAINED WEIGHT GAIN / LOSS
- ☐ 38. THYROID DISEASE
- ☐ 39. FAINTING SPELLS
- ☐ 40. SEIZURES
- ☐ 41. EPILEPSY
- ☐ 42. HEAD OR NECK SURGERY
- ☐ 43. HEAD OR NECK RADIATION
- ☐ 44. HEADACHE
- ☐ 45. KIDNEY DISEASES
- ☐ 46. HEPATITIS OR JAUNDICE
- ☐ 47. CANCER
- ☐ 48. IMMUNE SYSTEM DYSFUNCTION
- ☐ 49. NEED FOR ANTIBIOTICS PRIOR TO A DENTAL PROCEDURE?
- ☐ 50. ALCOHOL ABUSE
- ☐ 51. DRUG ABUSE
- ☐ 52. CHANGE IN APPETITE
- ☐ 53. INSOMNIA
- ☐ 54. TINGLING/ NUMBNESS
- ☐ 55. BLOOD DISORDERS
- ☐ 56. S.T.D
- ☐ 57. ANXIETY / DEPRESSION
- ☐ 58. DIABETES
- ☐ 59. ANEMIA
- ☐ 60. PROBLEMS WITH PREVIOUS ANESTHESIA
- ☐ 61. FAMILY MEMBER WITH PREVIOUS ANESTHESIA COMPLICATION
- ☐ 62. CONTACT LENSES
- ☐ 63. CHANCE OF BEING PREGNANT?
- ☐ 64. NURSING MOTHER
- ☐ 65. TAKING BIRTH CONTROL
- ☐ 66. OTHER (PLEASE SPECIFY): _____

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

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