LONE STAR DENTAL ANESTHESIA
4112 East Renner Road
Richardson, TX 75082
info@lonestarda.com

1. Who is your treating dentist?

_____

2. **Please enter your information here:**

Patient Last Name: _____ Patient First Name: _____ Patient Date of Birth: _____

Address: _____ Apt/Unit #: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Gender:
○ Male ○ Female

Height: _____ Weight in lbs: _____

Emergency Contact: _____ Phone Number: _____

If you are completing this form for another person, what is your relationship to that person?

_____

3. **Please answer the following questions. Your answers are for our records only and will be considered confidential.**

Please describe your current physical health?
○ Excellent ○ Good ○ Poor

Has there been any change in your general health within the past year?
○ Yes ○ No

My last complete physical exam was on: _____

When having blood drawn or an IV catheter placed, is it usually easy or difficult to find a vein?
☐ Easy ☐ Difficult ☐ Unsure

Date of last cold, cough, or fever: _____

Do you experience shortness of breath?
○ At rest ○ Minimal exertion
○ Moderate exertion
○ Heavy exertion

Please explain why:

_____

4. Primary Care Doctor: _____ Phone Number: _____

Are you currently under the care of any other physicians?
○ Yes ○ No

If so, what medical condition(s) are currently being treated?

Please list all other physicians currently being seen:

Physician's Name: Phone Number:

Physician's Name: Phone Number:

Physician Name: Phone Number:

5. Have you had any illness or operation/surgery that required hospitalization or had same-day surgery?

○ Yes ○ No

6. Please list any illnesses or operations:

7. Please describe your routine physical activity:

8. Do you have or have you had any of the following diseases or problems?

- ☐ Damaged heart valves
- ☐ Artificial heart valves
- ☐ Knee replacement
- ☐ Hip replacement
- ☐ Plastic or artificial arteries
- ☐ Congenital heart defect(s)
- ☐ Heart murmur
- ☐ Cardiovascular disease
- ☐ Heart trouble
- ☐ Heart attack
- ☐ Coronary insufficiency
- ☐ Coronary occlusion
- ☐ High blood pressure (hypertension)
- ☐ Atherosclerosis
- ☐ Stroke
- ☐ NONE

Please explain any 'yes' answers

9. Do you have chest pain upon exertion?
○ Yes ○ No

Do your ankles swell?
○ Yes ○ No

Do you get short of breath when you lie down, or do you require extra pillows when you sleep?
○ Yes ○ No

Do you have a cardiac pacemaker/defibrillator?
○ Yes ○ No

Do you have an arrhythmia or an irregular heart beat?
☐ Arrhythmia
☐ Irregular heart beat ☐ NONE

Have you ever been diagnosed with sleep apnea?
○ Yes ○ No

Have you ever had:
☐ Kawasaki's disease
☐ Rheumatic fever
☐ Scarlet fever ☐ NONE

Have you ever had:
☐ Asthma ☐ Bronchitis
☐ Emphysema
☐ Persistent cough
☐ Tuberculosis ☐ Wheezing
☐ Hay fever ☐ NONE

Have you ever had:
☐ Fainting Spells ☐ Seizures
☐ Epilepsy ☐ NONE

Please explain the cause of any fainting spells, seizures or epilepsy:

_____

Have you ever had:
☐ Diabetes
☐ Thyroid gland condition
☐ Pituitary gland condition
☐ Adrenal gland condition
☐ NONE

Have you ever had:
☐ Hepatitis ☐ Jaundice
☐ Liver disease ☐ NONE

Have you ever been told not to donate blood?
○ Yes ○ No

If yes, why?

_____

AIDS or tested positive for HIV?
○ Yes ○ No

Arthritis or inflammatory rheumatism?
○ Yes ○ No

Stomach ulcers?
○ Yes ○ No

Kidney trouble?
○ Yes ○ No

Low blood pressure?
○ Yes ○ No

Have you ever taken any "recreational" drugs in the past such as cocaine, crack, marijuana, LSD?
○ Yes ○ No

Do you have a history of alcoholism or drug dependence?
○ Yes ○ No

Are you currently or have you previously been under the care of a psychiatrist, or been hospitalized due to psychiatric care?
○ Yes ○ No

Please elaborate if you've selected "yes" to any psychiatric care

_____

10. If you have ever taken any "recreational" drugs in the past, please explain what and when:

_____

11. Do you have a history of smoking?
○ Yes ○ No

If yes, how many per day and for how many years?

_____

Do you have a history of drinking alcohol?
○ Yes ○ No

If yes, how much do you drink per day averaged over the week?

_____

Do you bleed or bruise easily?
○ Yes ○ No

Do you have:
☐ Hemophilia
☐ Von Willebrand Disease ☐ NO

Do you have any blood disorder, such as anemia or sickle cell anemia?
○ Yes ○ No

Have you ever received a blood transfusion?
○ Yes ○ No

Have you ever had any of the following for tumor, cancer, or any other condition:
☐ Surgery ☐ X-ray treatment
☐ Chemotherapy ☐ NO

12. Please list all medications you are currently taking. If no medications, please write 'NONE':

13. Please list all allergies to medication, latex, foods. If no allergies, please write 'NONE' :

14. Have you or a close relative ever had a bad reaction to any anesthetic drug?
○ Yes ○ No

Have you ever had complications during a previous anesthetic?
○ Yes ○ No

Do you have any disease, condition, or problem not mentioned above?
○ Yes ○ No

Please list any disease, condition, or problem not mentioned above:

15. Women only:

Is there any possibility that you are pregnant?
○ Yes ○ No

Are you a nursing mother?
○ Yes ○ No

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform the anesthesiologist of any changes in my medical status at the earliest possible time.

16. Who is your provider?

○ Jinsoo Kim ○ William Baltazar ○ Hasan Zia
○ Allison Lee

Signature of Patient

Signature Date

Reviewed by: Jinsoo Kim, DDS/William Baltazar, DDS/Hasan Zia, DDS/Allison Lee, DDS

Signature Date