

--- PRE-ANESTHESIA / PROCEDURE ASSESSMENT ---

Please complete within 90 days of appointment

Patient Name: _____ Dentist: ES/TR/DS/AT/BV Today's Date: _____

DOB: _____ Age: _____ Sex: M: ___ F: ___ Ht: _____ Wt: _____ above wst / below wst

Physician Info: _____ Pulse Ox: _____% BP: _____ HR: _____
Last Physical Exam: _____

PMH: _____

PSH/Anesthetic Hx: _____ Previous Sedation?

FAMILY: Prob w/Anesthesia Tobacco use?
 Coagulopathy SOCIAL: Alcohol use?
 Drug use?

SOCIAL: Tobacco
 EtOH
 Drug

Notes / Misc: _____

ALLERGIES: _____ GRAPEFRUIT JUICE: _____ Y N

REVIEW OF SYSTEMS: _____ | MEDICATIONS: (DOSE, ROUTE, FREQUENCY) NONE
WNL ABNORMAL/COMMENTS |
 GENERAL |
 HEENT |
 NECK |
 CARDIOVASCULAR |
 PULMONARY |
 GI |
 EXTREMITIES | Supplements/OTC drugs:
 SKIN |
 NEURO |

Brodsky: 1 2 3 4 IV Access: Easy Moderate Difficult
Mallampati: 1 2 3 4 Short Neck: Y N
Opening: Normal Limited Skeletal Class II: Y N
Neck Mobility: Normal Limited Prior Anesthesia difficulty: Y N
ASA: 1 2 3 4

Recommended Pre-Op meds: _____

Doctor Signature: _____ Patient/Guardian Signature: _____

Date: _____ Date: _____