Pre-Anaesthesia Questionnaire (Adult) Date of Birth: _____

Name _____Date _____

	Yes	No	Not sure
1.Do you have any health problems or concerns presently? Please explain:_____	☐	☐	☐
2. Has there been ANY change in your general health in the past year? When did you last have a complete physical exam? (month)_____ (year) ___ How often do you see your family doctor or specialist? Every_____	☐	☐	☐
3. Have you ever been in hospital for treatment? _____ When, where and why? _____	☐	☐	☐
4. Have you ever had general anaesthesia or surgery? _____ When, where and why? _____ Were there any problems with the anaesthesia? _____	☐	☐	☐
5. Have you or any of your family relatives had problems with anaesthesia? Please explain. Were any tests done?	☐	☐	☐
6. Do you have a drug allergy? What drug? What year? What happened? (Circle) rash breathing problems/wheezing swelling	☐	☐	☐
7. Do you have any other allergies (e.g. latex)? _____	☐	☐	☐
8. Do you take ANY medications (including puffers and birth control pills)? Please list or bring a list of all of your medications or bring them to the office: Name Dose	☐	☐	☐
9. Do you use or take ANY non-prescription remedies (including herbal remedies)? Name _____ Dose: _____	☐	☐	☐
10. Have you taken a cortisone (steroid) type drug orally in the past year? When? How long were you taking it for	☐	☐	☐
11. Do you or any of your relatives have a bleeding problem?	☐	☐	☐
12. Do you have or have had any difficulty breathing through your nose?	☐	☐	☐
13. Do you have any nose bleeds? If so, how many per week? _____	☐	☐	☐
14. Do you have or have had any difficulty breathing while sleeping at home?	☐	☐	☐
15. Can you walk up 2 flights of stairs or 2 city blocks quickly without resting?	☐	☐	☐

Pre-Anaesthesia Questionnaire (Adult) cont'd

Name_____ **Age** _____

16. Do you have or have you ever had any of the following?

	Yes	No	Not Sure		Yes	No	Not Sure
Heart murmur				Fainting spells, dizziness			
Heart attack				Diabetes			
Chest pain or angina				Thyroid problems			
Shortness of breath lying down				Adrenal gland problems			
Swollen ankles				Hepatitis			
Heart pacemaker/defibrillator				Liver disease / Jaundice			
Irregular heart beat/arrhythmia				Anemia (including sickle cell)			
High blood pressure				Blood disorders/transfusions			
Congenital heart disease				Bleeding (Coagulation) disorders			
Damaged/abnormal heart valves				Stomach ulcers/ Acid Reflux			
Rheumatic fever				Bone, joint, or muscle problems			
Kidney disease				Artificial joints – hips, knees			
HIV, AIDS or STD				Arthritis			
Malignant hyperthermia				Depression / anxiety			
Pseudocholinesterase deficiency				Vision problems / glaucoma			
Cancer / Chemotherapy				Mentally disabled			
Sleep apnea				Cerebral palsy			
Asthma				Autism or Down's syndrome			
Emphysema / Bronchitis				**WOMEN:**			
Cystic fibrosis / Tuberculosis				Are you pregnant?			
Epilepsy				Are you a nursing mother?			
Stroke				Any problems with menstruation?			

	Yes	No	Not sure
17. Do you ever have episodes of blurred vision or black spots, or experience weakness or paralysis on one side of your body, arms, legs or face?	☐	☐	☐
18. Do you have any problems opening your mouth wide or moving your neck fully?	☐	☐	☐
19. Have you ever had surgery, radiation or chemotherapy treatment for a tumour or cancer?	☐	☐	☐
20. Do you smoke, if so how much? _____	☐	☐	☐
21. Do you drink more than 5 alcoholic beverages per week? Number/week _____	☐	☐	☐
22. Do you have a history of alcoholism or drug dependence?	☐	☐	☐
23. Have you taken any "recreational" drugs in the past year such as marijuana, LSD, PCP, cocaine, crack, 'crystal meth', codeine, oxycodone or other drugs?	☐	☐	☐
24. Do you have ANY disease, condition or problem not listed above? _____	☐	☐	☐

25. **How much do you weigh?**_____ **Height**_____

26. Additional comments:_____

Signature: **Date:**

PRE-OPERATIVE INSTRUCTIONS FOR PATIENTS WHO WILL BE RECEIVING INTRAVENOUS SEDATION OR ANESTHESIA

1. Nothing to eat or drink (including water) for 8 hours before the procedure.
2. The only exception to the above instruction applies if you take medications on a regular basis. Take your usual medications at (approximately) the regularly scheduled times at least two hours before the appointment, with a few sips of water (and water only).
3. Arrangements must be made to have a responsible adult take you home, by car or taxi (a taxi driver alone is not allowed to take you home). You may NOT go home by public transit.
4. Please wear something short-sleeved (eg, t-shirt). Do not wear facial makeup or nail polish.
5. Contact us prior to the appointment if has there been a change in your general health (egs, severe cold, fever, etc.)

INSTRUCTIONS FOLLOWING YOUR SEDATION/ANESTHESIA APPOINTMENT

1. You may be drowsy for the remainder of the day and should be relaxing at home in the care of a responsible adult until you are fully alert.
2. You must not drive a car or operate machinery for at least 18 hours, longer if drowsiness or dizziness persists.
3. Replenish your energy by having something to eat or drink as soon as possible.
4. Do not drink alcoholic beverages for a minimum of 18 hours after the procedure.
5. Do not sign any important or legal documents for 24 hours.
6. If there are any questions or concerns, contact the dental office. In case of an emergency, you should go to the nearest emergency room.

POST-OPERATIVE INSTRUCTIONS

DR. BRIAN KUMER

416 605 0008

PLEASE READ THESE INSTUCTIONS CAREFULLY. Sometimes the after-effects of oral surgery are quite minimal, so not all of these instructions may apply. Common sense will dictate what you should do. However, when in doubt, follow these guidelines or call us for advice.

DAY OF SURGERY (FIRST 24 HRS)
AND DAYS 2-7

FIRST HOUR

Bite down gently but firmly on the gauze packs that have been placed on the surgical sites, making sure they remain in place. Do not change them for the first 30 minutes unless the bleeding is not being controlled. If active bleeding persists after 30 minutes, place enough new gauze to obtain pressure over the surgical site for another 30 minutes. The gauze may be changed as necessary and may be dampened for more comfortable positioning. Do not disturb the surgical area today. NO RINSING, WHATSOEVER, DURING THIS PHASE. DO NOT SMOKE. Smoking increases the risk of dry socket dramatically.

OOZING/BLEEDING

It's normal to have your saliva stained with blood for a few days. There may also be some slight oozing. If this persists, place fresh gauze over the area and bite down for 30-60 minutes. Bleeding should never be severe. If it is, it usually means the gauze packs are placed between your teeth and not over the surgical sites. Try to reposition them. If this doesn't work substitute a moistened tea bag wrapped in moist gauze for 30-60 minutes. Do not sleep with gauze in your mouth. When sleeping use an old pillow and place some towels around your head to protect your bedding. If bleeding remains uncontrolled please call us.

SWELLING

Often there is swelling/bruising associated with oral surgery. Swelling is a normal response to trauma. It is not the same as infection. If you are swollen this does not mean you are infected. You can minimize this by using an ice pack applied to the face adjacent to the surgical site. The ice should be applied in 15-20 minute intervals over a 24-48 hour period. After the first 24-48 hours, stop icing the area. Do not use ice packs while sleeping. Despite icing the area, swelling will still occur. After 48 hours, apply a warm moist compress for 30 min of every hour for the balance of the week. Swelling usually increases over a 72 hour period. Therefore you will appear more swollen on the 3rd day than the 2nd day. After 72 hours, swelling starts to slowly subside and is mostly gone by the 7th day.

RINSING

After the first 48 hours have elapsed you may stop icing the area. At this time start with warm salt water rinse. Place a teaspoon of salt in a glass of warm water. Gently swish it around your mouth 2-3 times a day for the next 7-10 days. Do not spit out the rinse. Let it fall out of your mouth. Spitting exerts a force on the healing clot and can slow down healing and promote bleeding. Do not use mouthwash for the first 7 days unless prescribed by the dentist. Use your prescription mouthwash 2-3 times /day. Also you may brush in the area unaffected by the surgery but leave the surgical areas alone for 4-6-3 days. After that you may gently clean around the area although swelling and soreness may not permit you to do so. In time, you will be able to return to proper oral hygiene care.

PAIN

Unfortunately oral surgery is usually accompanied by some degree of discomfort. You may have been given some pain medication prior to the start of your procedure. It is important to follow the instructions with pain medication as it is easier to "stay ahead of the pain rather than trying to catch up to it." If you take the first pain pill before the local anesthetic has worn off you will be able to manage the discomfort better. Alternate between your prescription pain medication and Ibuprofen on a 3 hour cycle.

Ibuprofen>>>3hrs>>>Prescription>>>Ibuprofen>>>Prescription

Follow this until the prescription medication is no longer needed. Continue with the Ibuprofen until no longer needed.

INFECTION

Unless you present with infection you usually don't develop an infection in the first few days. Antibiotics are prescribed to either help prevent infections from developing or to treat an infection that is present. Not all procedures require an antibiotic. There is a decrease in effectiveness of birth control medication when taking antibiotics. Consult your physician for advice on additional birth control measures. Slightly elevated temperature may occur for reasons other than infection. Be sure to drink lots of fluids: 1.5-2 liters /day.

DIET

Soft food is the dietary choice for the first few days. Ice cream, Jell-O, pudding, mashed potatoes, soups, pasta, or baby food are good choices. Avoid foods like nuts, popcorn, and rice as they tend to get stuck in the socket areas. Drinks like ENSURE or BOOST are good supplements as well. **DO NOT USE A STRAW OR DRINK FROM A BOTTLE** for the first 2-3 days. This can exert a force on the blood clot and slow down healing and promote bleeding. Use a spoon or a cup. After the fourth day you can progress to solid foods at you own pace. It is important to eat as you will feel better and heal faster. If you are diabetic, maintain you normal eating habits as much as possible and consult your physician regarding your insulin schedule.

STITCHES

You may have had some stitches placed. They will dissolve on their own in 5-7 days. Not all surgical sites require stitches. If a stitch comes out it is of no concern provided there is no excessive bleeding.

SMOKING

Do not smoke! It is advisable not to smoke for at least 72 hours.

SYRINGE

You will be given an irrigating syringe at your appointment. Fill a cup with salt water and then fill the syringe. Gently place it in the LOWER SOCKET ONLY and irrigate it 2-3 times. Do this after each meal over the next three to four weeks until the sockets close up. **DO NOT USE THE SYRINGE UNTIL 5 DAYS AFTER YOUR SURGERY!**

REST

You need to give your body time to heal following surgery. No physical activity is recommended for 1-2 days if the procedure was minor and 5-7 if it was more involved.

It is our desire that your recovery be as smooth as possible. Following these instructions will assist you, but if you have any questions please call our phone number.

SHOULD YOU BE UNABLE TO REACH ME IN AN EMERGENCY, GO TO THE NEAREST EMERGENCY ROOM

DR. BRIAN KUMER 416 605-0008

Endodontic (Root Canal) Therapy Post Operative Instructions

Root canal therapy disinfects the inside of the root of an infected tooth. Since every tooth can heal differently, it is hard to predict exactly what your experience will be. Discomfort or soreness in the area is normal for a few days (or up to 10 days) and can range from commonly mild to occasionally severe. This does **not** mean there is a problem with the root canal treatment. This occurs because of any existing infection and inflammation of the gum and tooth ligaments as well as the manipulation of the tooth during treatment. The gums may be sore and the tooth is often tender to biting or chewing.

If you are not allergic, taking Advil or Tylenol should relieve most of the discomfort. If you have been given a prescription please take as directed. **Discomfort in the area in no way affects the successful outcome of treatment.** Should you develop swelling, please contact the office so that an antibiotic can be prescribed and/or further evaluation.

Occasionally, there can be a flareup of infection and/or pain following treatment. The cause for this is unpredictable and unknown and following these instructions should help minimize the discomfort.

Most commonly, a temporary filling has been placed. These fillings can wear away or even come out. This is **not** an emergency. The root canal system is sealed underneath that temporary filling. Please contact the office if you feel you need the temporary filling replaced prior to your final restoration appointment.

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POST OP FOR DENTAL IMPLANTS

1) **Smoking:** Do not smoke. Patients who smoke will experience delayed healing and greater discomfort and are at higher risk for infection. In addition smoking will compromise your result.
2) **Medication:** It is important to follow the instructions written on your prescription. If you experience any unfavourable reactions such as nausea, vomiting, diarrhea, rash, etc. call the doctor.
3) **Rest:** Do not plan on any activities for the remainder of the day. Avoid any strenuous activity for 1 week following surgery.
4) **Pain:** Some discomfort is expected once the anesthetic wears off. If you were prescribed post-operative pain medication, begin taking it before the anesthetic wears off to minimize discomfort. Ibuprofen is an effective pain medication and also reduces swelling. It can be taken for the first 3-4 days on a continuous basis (4 times per day) with a maximum dose of 3 grams per day. You may take Ibuprofen in addition to and at the same time as a prescribed narcotic such as Tylenol #2 or #3.
5) **Swelling:** Some swelling may occur the day after surgery and will generally persist for 24-36 hours, then diminish. Swelling can be minimized by placing an ice pack on the outside of the face over the surgical site alternating on and off in 10 minute intervals. You should do this for the 24 hours following your surgery.
6) **Bleeding:** There should be no outright bleeding after surgery, though a slight pinkish colour to your saliva is common. If bleeding occurs, place a moistened non herbal tea bag over the area and apply gentle pressure. Continue this for 20 minutes. If bleeding persists call the doctor.
7) **Rinsing:** Following your surgery you should rinse with warm salt water for the next 24 hours. Do not brush or floss or water pik in the area involved in the surgery. If you have been prescribed mouthwash use it twice daily until the stiches are removed. Make sure there is no toothpaste in your mouth when rinsing.
8) **Diet:** It is important to maintain a normal healthy diet. Do not drink any hot drinks for the first 24 hours. The 4 days following surgery eat soft foods (oatmeal, cottage cheese, eggs, avocado, fruit and vegetable juices) Try to do your chewing on the opposite site of your mouth from where the surgery took place. Avoid any coarse foods such as seeds, nuts, chips, popcorn etc. . . . It may be necessary to maintain a liquid diet for a few days. Increase your fluid intake during this time. Avoid using a straw for 4 days.

IMPLANT SURGERY

INFORMATION AND CONSENT FORM

_____(Date)

1) I have been informed of and I understand the purpose and nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.

2) My doctor has carefully examined my mouth and explained alternatives to this treatment have been explained to me. I have either tried or have considered these options and have concluded that an implant is my treatment of choice to secure the tooth or denture to be replaced.

3) I have further been informed of the possible risks and complications involved with surgery, drugs (allergic or adverse reactions) and anesthesia. Such complications include pain, swelling, infection, bruising. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Other possible risks are injury to other teeth, bone fractures, sinus perforation, delayed healing, rejection of the implant.

4) It has been explained to me that in some instances implants fail and must be removed. The success rate of dental implant surgery is very high but dentistry is not an exact science and no guarantee or assurance as to the outcome of the result of treatment can be made.

5) I understand that if nothing is done any of the following could occur: loss of bone and/or gum tissue, inflammation of the gums, infection, loose teeth, loss of teeth, and the occurrence or reoccurrence of Temporomandibular (jaw) joint symptoms

6) I understand that excessive smoking, alcohol, or sugar may affect healing and may limit the success of the implant. I agree to follow my doctors home care instructions. I agree to report to my doctor for regular examinations as instructed.

7) To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, reported any bleeding disorders or any other condition related to my health

8) I consent to the photographing filming videotaping of the procedure to be performed provided my identity is not revealed.

9) I request and authorize the dental services for me, including implants and other surgical procedures as deemed necessary to accomplish the placement of the implants. I fully understand that during and following the procedure conditions may become apparent that warrant additional or alternative treatments pertinent o the success of the comprehensive treatment. I also approve any modification in the design or materials if it is felt to be in my best interest.

10) The fees for this treatment plan and the payment plan have been explained to me and I have approved them.

_____ _____

Signature of patient Signature of witness (REV JAN/13)