HADDONFIELD DENTAL

Specialized Dentistry. Personalized Care

**New Patient Sedation Track Supplement**

**Please provide the following information**

- Do you believe that you need sedation to have dental work done? **YES or NO**

- What is the cause or source of the need for sedation?
  - Fear- when did it begin? _____
  - Gagging- roof of the mouth, side of the tongue, do you gag when brushing teeth? **YES or NO**
  - Claustrophobia
  - Previous dental experience _____
  - Other (please describe) _____

- Have you been sedated before? **YES or NO**
  - IV? **YES or NO**. Difficulty getting IV started? **YES or NO**
  - Oral (Pills) **YES or NO**
  - Nitrous Oxide (Laughing gas)? **YES or NO**
  - Describe the experience:_____
  - Any complications? _____

- Do you have any of the following in your mouth:
  - Fixed
  - Removable
  - Implant

- Are you opposed to wearing or having:
  - Fixed bridged- **YES or NO**---Why? _____
  - Removable Dentures- **YES or NO**---Why?_____
  - Implants- **YES or NO**---Why? _____

- What is the most important to you:
  - Relationship with dentist
  - Overall Dental health
  - Visit today (Pain, etc.)

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# HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:
_____
_____
_____
_____

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

| | | | | | |
|---|---|---|---|---|---|
| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
| Arthritis, Rheumatism or other inflammatory disease? | No | Yes | Joint Replacement? When placed? | No | Yes |
| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | Psychosis | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Previous Biopsies | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Rheumatic Fever | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |

## HEALTH HISTORY (cont.)

| | | | | | |
|---|---|---|---|---|---|
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS or ARC | No | Yes |
| Congenital Heart Disease | No | Yes | Venereal Disease | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Other Conditions | No | Yes |
| Heart Stent? When placed? | No | Yes | Recurrent Illnesses | No | Yes |

Are you taking any of these medications?

| | | | | | |
|---|---|---|---|---|---|
| Pre-medication before dental treatment? | No | Yes | Tagamet® (cimetidine) or Prilosec® (omeprazole)? | No | Yes |
| Antacids? | No | Yes | Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)? | No | Yes |
| Dilantin® or Tegretol® | No | Yes | Serzone® (nefazodone) | No | Yes |
| Barbiturates (any) | No | Yes | Diflucan® (fluconazole) or Sporonox® (itraconazole) | No | Yes |
| St. John's Wort or Kava-Kava? | No | Yes | Biaxin® (clarithromycin) | No | Yes |
| Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end? | No | Yes | | | |
| Have you ever taken any prescription drugs such as fen-phen for weight loss? | No | Yes | | | |
| Do you consume grapefruit juice, grapefruits or grapefruit extract? | No | Yes | | | |
| | | | | | |

## HEALTH HISTORY (cont.)

| | | |
|---|---|---|
| | | |

Please list any medications you are currently taking and dosages:

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please list any dietary or herbal supplements you are taking, and for what purpose:

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| | | |
|---|---|---|
| Women: Are you pregnant? | No | Yes |
| If no, are you planning a pregnancy in the near future? | No | Yes |
| Are you a nursing mother? | No | Yes |
| Are you taking birth control pills? | No | Yes |
| Abnormal Blood Pressure? (Please circle) | No | Yes |
| Have you ever received a diagnosis of "high blood pressure"? | | |

What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

| | | |
|---|---|---|
| Local anesthetics …….. | No | Yes |
| Penicillin or other antibiotics …… | No | Yes |
| Aspirin, Ibuprofen or Tylenol …..…… | No | Yes |
| Codeine, Valium® or other sedatives…… | No | Yes |

Latex or Metals

Other (please specify)_____

Tobacco, Alcohol, Drugs

| | | |
|---|---|---|
| Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long? | No | Yes |
| Do you want to quit using tobacco? | No | Yes |
| Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? | No | Yes |
| Do you use any mood altering drugs other than those previously listed? | No | Yes |

Weight and Diet considerations

| Weight | Meals per Day | Dietary Restrictions | Food Allergies |
|---|---|---|---|
| | | | |

Sugar in your diet (circle one): *none slight moderate high*

## HEALTH HISTORY (cont.)

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____
_____
_____

Significant findings from questionnaire or oral interview:

_____
_____
_____

Dental management considerations:

_____
_____
_____

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

| _____ | _____ | _____ |
|---|---|---|
| *Patient (Print Name)* | *Patient Signature* | *Date* |
| _____ | _____ | _____ |
| *Doctor (Print Name)* | *Doctor Signature* | *Date* |

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# Medical Considerations for Oral/IV Sedation

Are you pregnant? Y / N

Do you **currently** or have you **ever had** a history of alcohol, opioid, benzodiazepine, or barbiturate abuse? Y / N
If so, please explain.

_____

Do you take any form of recreational drugs? Y / N
If so, please list.

_____

Are you allergic or have you ever had a hypersensitivity to **benzodiazepines or opioids**? Y / N

Do you have any form of Glaucoma? Y / N If yes, please circle which one (Narrow or Wide Angle).

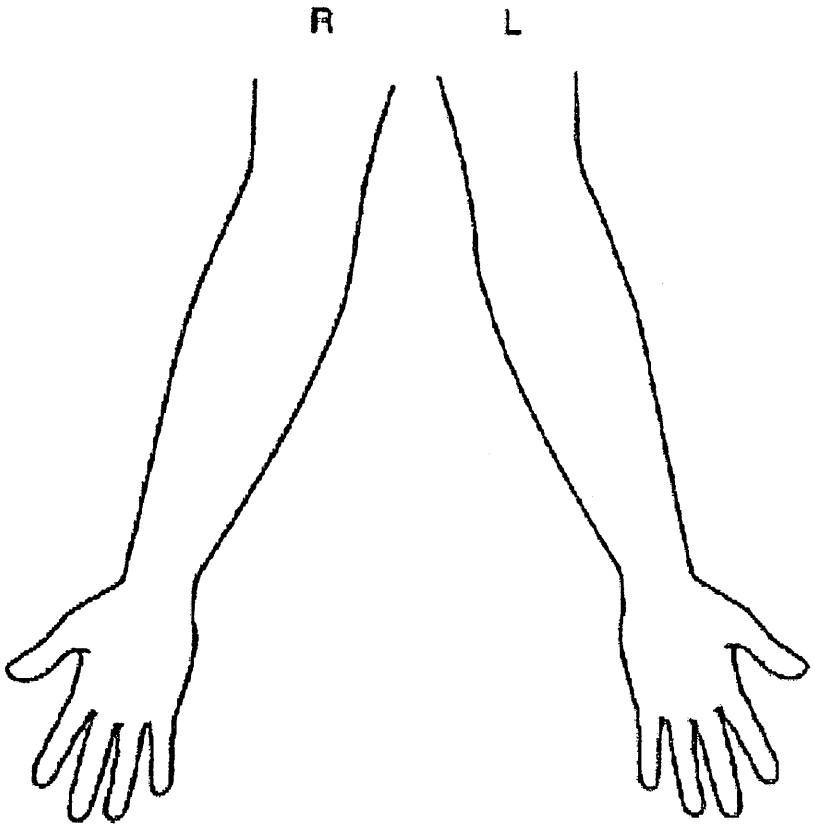
Do you currently have or have a family history of Malignant Hyperthermia? Y / N

Do you have any form of Respiratory Depression or Problems Breathing? Y/ N
If so, please describe.

_____

Do you have any Kidney or Liver problems? Y / N

Have you ever been diagnosed with or have any family history of Psychiatric Disorders? Y / N




Please circle area where you have successfully had IV line started in the past .