Oral Sedation Evaluation-HEALTH HISTORY

Name________________________________ Date of Birth ______________ Date_____________________

Date of Last MEDICAL Exam________________ What was this exam for? ____________________________

Have you been hospitalized in the past 5 years? Please circle: NO YES

If yes, reason: ____

Are you currently receiving medical 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:

1. ____

2. ____

3. ____

4. ____

For the following questions, please circle yes or no, if you now have or have ever had the listed issues. *Your 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	Mitral Valve Prolapse	No	Yes
Arthritis, Rheumatism or Other Inflammatory Disease	No	Yes	Hepatitis, Any Form	No	Yes
Asthma	No	Yes	Joint Replacement/ Artificial Joints/ Prostheses When Placed:	No	Yes
Abnormal Bleeding From a Cut	No	Yes	Kidney Disease/ Kidney Problems	No	Yes
Cancer or Tumor	No	Yes	Liver Disease (Including Jaundice)	No	Yes
Diabetes	No	Yes	Sore/ Enlarged Lymph Nodes	No	Yes
Emphysema or Other Respiratory/ Lung Illness	No	Yes	Pacemaker	No	Yes
Epilepsy	No	Yes	Psychosis	No	Yes
Fainting or Dizzy Spells	No	Yes	Previous Biopsies	No	Yes
Glaucoma	No	Yes	Radiation or Chemotherapy	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Rheumatic Fever	No	Yes
Heart Valve (Artificial) or Heart Transplant	No	Yes	Slow-Healing Mouth Sores	No	Yes
Congenital Heart Disease	No	Yes	Unintentional Weight Loss or Weight Gain	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	H.I.V. Infection/ AIDS or ARC	No	Yes
Heart Stent Date Placed:	No	Yes	Venereal Disease	No	Yes
Artificial Heart Valve Implant	No	Yes	Stomach Problems	No	Yes
Heart Murmurs	No	Yes	Psychiatric Treatment	No	Yes
Liver Problems	No	Yes	Tuberculosis	No	Yes
Recurrent Illnesses	No	Yes	Other illness/ problem not listed above	No	Yes

Please tell us about any diseases or problems not covered in prior list/ or if you circled “Yes” to “Other illness/ problem not listed above”:

___

___

Are you taking any of these medications?

Fish Oil	No	Yes	Tagament® (cimetidine) or Prilosec®	No	Yes
Antacids Name of Antacid:	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 Wart or Kava Kava	No	Yes	Biaxin® (clarithromycin)	No	Yes

Have you been treated with Bisphosonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®) for bone tumors, excessive calcium in your blood, or osteoporosis? If so, when did treatment begin and end:	No	Yes
Have you ever taken any prescription drugs such as Fen-phen/ fenfluramine/ fenfluramine combined with phentermine, dexfenfluramine (redux), or other prescription drugs for weight loss?	No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit juice extract?	No	Yes

Please list ANY medications you are currently taking and dosages:

Medication Name:	Dosage:	How often:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Please list ANY dietary or herbal supplements you are currently taking and for what purpose:

Supplement Name:	Dosage:	How often:
1.		
2.		
3.		
4.		

Women: Is there any chance you may be 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)
Have you ever been told you have "low blood pressure?" NO YES
Have you ever received a diagnosis of "high blood pressure?" NO YES
What is your normal blood pressure? S ____ /D ____

Are you allergic or have you had a reaction to:
a. Local Anesthetics NO YES
b. Penicillin or other antibiotics ________________________ NO YES
c. Aspirin, Ibuprofen or Tylenol® NO YES
d. Codeine, Valium® or other sedatives __________________ NO YES
e. Latex or Metals NO YES
f. Other (Please Specifiy) ____

Tobacco, Alcohol, Drugs

Question	No	Yes
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
Do you habitually use controlled substances?	No	Yes

Weight and Diet Considerations

Weight	Meals Per Day	Dietary Restrictions	Food Allergies

Amount of Sugar in Your Diet (circle one): None Slight Moderate High

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 information to you. I will notify the doctor of change in my health and medication.

_________________________________ _________________________________
Patient (Print Name) Patient (Signature)

Date ______________________________

Oral Conscious (or Minimal) Sedation ("OCS")
Informed Consent Form

The purpose of this document is to provide an opportunity for patients to understand and give permission for oral conscious (or minimal) sedation ("OCS") when provided along with dental treatment. ***Each item should be initialed by the patient.***

_____1. I understand that the purpose of OCS to more comfortably receive necessary care. OCS is not required to provide the necessary dental care. I understand that OCS has limitations and risks and absolute success cannot be guaranteed. (See #4 options.)

_____2. I understand that OCS is a drug-induced state of reduced awareness and decreased ability to respond. OCS is not sleep. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedative wear-off.

_____3. I understand that my conscious sedation will be achieved by the following route:

- _____ Oral Administration: I will take a pill approximately _60___ minutes before my appointment (and possibly more during). The sedation will last approximately __4__ to _6___ hours.

_____ 4. I understand that the alternatives to OCS are:

- _____ A. No sedation: The necessary procedure is performed under local anesthetic with the patient fully aware.
- _____ B. Nitrous oxide sedation: Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally ware of surrounding activities. Its effects can be reversed in five minutes with oxygen
- _____ C. Anxiolysis: Taking a pill to reduce fear and anxiety.
- _____ D. Oral conscious (or minimal) sedation: Sedation via pill form that will put me in a minimally depressed level of consciousness.
- _____ E. Intravenous (I.V.) conscious (or moderate) sedation: The doctor could inject the sedative in a tube connected to a vein in my arm to put me in a minimally to moderately depressed level of consciousness.
- _____ F. General anesthetia: Also called deep sedation, a patient under general anesthetic has no awareness and must have their breathing temporarily supported. General anesthesia is more appropriate for longer procedures lasting three or more hours.

_____5. I understand that there are risks or limitations to all procedures. For sedation, these include:

- _____ (Oral Sedation) Inadequate sedation with initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time. Likewise, in compliance with state regulations, an additional dose or doses may be required to complete the procedure.
- _____ Atypical reaction to sedative drugs which may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions, and other sicknesses.
- _____ Inability to discuss treatment options with the doctor should circumstance require a change in treatment plan.

_____ 6. If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

_____7. I have had the opportunity to discuss OCS and have my questions answered by qualified personnel including the doctor. I also understand that I must follow all the recommended treatments and instructions of my doctor.

_____ 8. I understand that I must notify the doctor if I am pregnant, or if I am lactating. I must notify the doctor if I have sensitivity to any medication, of my present mental and physical condition, if I have recently consumed alcohol, and if I am presently on psychiatric mood altering drugs or medications.

_____ 9. I will not be able to drive or operate machinery while taking oral sedatives for 24 hours after my procedure. I understand I will need to have arrangements for someone to drive me to and from my dental appointment while taking oral sedatives.

____ 10. I hereby consent to OCS in conjunction with my dental care.

______________________________ ______________ ____________________

Patient/ Guardian Signature Date Witness

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Drs. Michels and Gauquie

After Sedation Instructions for Companion and Patient

PATIENT READS AND SIGNS THIS FORM—A COPY OF THIS FORM IS ATTACHED—YOU DO NOT HAVE TO SIGN THE SECOND COPY—THE SECOND COPY WILL BE GIVEN TO THE PERSON THAT BRINGS YOU TO YOUR SEDATION APPOINTMENT

1. PATIENT CANNOT DRIVE FOR 24 HOURS AFTER TAKING SEDATION MEDICATION.
2. DO NOT OPERATE ANY HAZARDOUS DEVICES FOR 24 HOURS.
3. A RESPONSIBLE PERSON SHOULD BE WITH THE PATIENT UNTIL HE/SHE HAS FULLY RECOVERED FROM THE EFFECTS OF SEDATION.
4. PATIENT SHOULD NOT GO UP AND DOWN STAIRS UNATTENDED. LET THE PATIENT STAY ON THE GROUND FLOOR UNTIL RECOVERED.
5. HAVING NUTRITION AFTER SEDATION IS IMPORTANT. THE PATIENT SHOULD BEGIN EATING APPROPRIATE FOOD AS SOON AS POSSIBLE. DO NOT DELAY.
6. PATIENT NEEDS TO DRINK PLENTY OF FLUIDS AS SOON AS POSSIBLE.
7. PATIENT MAY SEEM ALERT WHEN HE/SHE LEAVES. THIS MAY BE MISLEADING SO DO NOT LEAVE THE PATIENT ALONE.
8. ALWAYS HOLD PATIENT'S ARM WHEN WALKING.
9. CALL US IF YOU HAVE ANY QUESTIONS OR DIFFICULTIES. IF YOU FEEL THAT YOUR SYMPTOMS WARRANT A PHYSICIAN AND YOU ARE UNABLE TO REACH US, GO TO THE CLOSEST EMERGENCY ROOM IMMEDIATELY.
10. PATIENT SHOULD NOT CARRY, SLEEP NEXT TO, OR BE LEFT ALONE WITH YOUNG CHILDREN FOR A PERIOD NO LESS THAN 24 HOURS AFTER THE LAST DOSAGE OF MEDICATION.
11. **DRIVE DIRECTLY HOME. CALL THE OFFICE WHEN YOU ARRIVE AT HOME AND THE PATIENT IS COMFORTABLE AND SAFE.**

Following most surgical procedures, there may or may not be pain, depending on your threshold for pain. You will be provided with medication for discomfort that is appropriate for you. In most cases, a non-narcotic regimen will be given consisting of acetaminophen (Tylenol®) and ibuprofen (Advil®). These two medications taken together, will be as effective as a narcotic without any of the side effects associated with narcotics. If a narcotic has been prescribed, follow the directions carefully. If you have any questions about these medications interacting with the other medications you are presently taking, please call our office, your physician, and/or your pharmacist.

______________________________ ______________________________

Patient Signature **Date**

______________________________ ______________________________

Companion Signature **Date**

MEDICATIONS: Take only when checked

- ☐ AMOXICILLIN- Fill prescription and take as directed
- ☐ ERYTHROMYCIN- Fill prescription and take as directed
- ☐ TYLENOL® (ACETAMINOPHEN)- Take two every 6 hours
- ☐ ADVIL® (IBUPROFEN)- Take two every 6 hours
- ☐ LORATAB- For PAIN ONLY- Take one every 6 hours
- ☐ VITAMIN C- Take one (1000mg) at every meal 3x a day
- ☐ Co Q 10- 50mg 2x a day

Drs. Michels and Gauquie

After Sedation Instructions for Companion and Patient

COMPANION'S COPY TO BE GIVEN AT SEDATION APPOINTMENT AFTER COMPANION SIGNS ORGINAL

12. PATIENT CANNOT DRIVE FOR 24 HOURS AFTER TAKING SEDATION MEDICATION.
13. DO NOT OPERATE ANY HAZARDOUS DEVICES FOR 24 HOURS.
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Patient Signature **Date**

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Companion Signature **Date**

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