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:

1. ____
2. ____
3. ____
4. ____

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.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagament (Cimetidine)?	No	Yes
Antacids?	No	Yes	Herbal supplements?	No	Yes
Have you been treated with Bisphosphonate drugs?				No	Yes

Please list any medications you are currently taking:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________

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
If yes, what is it usually: 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 ….………………..……………………………………………...No Yes
d. Codeine, valium or other sedatives……………………………………..… No Yes
e. Other ____

Are you a smoker? No Yes
If so, how much do you smoke per day? _________________

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Weight: __________

Diet: Restricted Diet ____________________________________
How many meals a day ______________________________
Food Allergies ____________________________________
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

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*

INFORMATION UPDATE

Have you had a change in your health since your last visit? No Yes

Heart (Surgery, Disease, Attack)	No	Yes	Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Rheumatic Fever	No	Yes
Joint Replacement	No	Yes	H.I.V. Infection/AIDS	No	Yes
Taken Fen-phen or other diet pills	No	Yes			

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes Are you a nursing mother? No Yes

Please list any medications you are currently taking:
1. ____________________________ 3. ____________________________
2. ____________________________ 4. ____________________________

Do you have any allergies? ? No Yes List: ____________________________________

Notes: ____
____
____

Signature ____ Date ____________________

Signature ____ Date ____________________

Signature ____ Date ____________________

After Sedation Instructions for Companion & Patient

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 THE 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 THE YOUNG CHILDREN FOR A PERIOD OF 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 & 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 PAIN 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 AFFECTS ASSOCIATED WITH NARCOTICS. IF A NARCOTIC HAS BEEN PRESCRIBED, FOLLOW THE DIRECTIONS CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THESE MEDICATIONS INTERACTING WITH OTHER MEDICATIONS YOU ARE PRESENTLY TAKING, PLEASE CALL OUR OFFICE, YOUR PHYSICIAN AND/OR YOUR PHARMACIST.

DR.'s Cell # (770) 480-9147 DATE:
COMPANIONS'S SIGNATURE: PATIENT'S SIGNATURE:

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-one(1000mg) at every meal 3x a day
- ☐ Co Q 10 - 50mg 2 x a day

Dr. Roya Akbar
General, Cosmetic and Sedation Dentistry

NITROUS OXIDE INFORMED CONSENT FORM

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for the use of Nitrous Oxide when provided along with dental treatment. Each item should be checked off after the patient (and/or parent or guardian) has had the opportunity for discussion and questions.

__________ 1. I accept and understand that Nitrous Oxide is commonly called laughing gas and provides relaxation, although I will be awake, fully conscious, aware of my surroundings, and able to respond rationally to inquires and directions.

__________ 2. I accept and understand that the use of Nitrous Oxide is not required to provide the necessary dental care.

__________ 3. I accept and understand that the purpose of Nitrous Oxide is to make it more comfortable for me to receive the necessary dental care with less pain and/or anxiety. I also accept and understand that the use of Nitrous Oxide has limitations and risks and absolute success cannot be guaranteed. (See also #5, below.)

__________ 4. I accept and understand that Nitrous Oxide will be administered by way of the inhalation route.

__________ 5. I accept and understand that the alternatives to Nitrous Oxide are:

__________ a. No Nitrous Oxide: The necessary procedure is performed under local anesthetic only.

__________ b. Anxiolysis: A pharmacologically induced state of consciousness where an individual is awake but has decreased anxiety to facilitate coping skills, retaining interactive ability.

__________ c. Oral Conscious Sedation: Sedation via pill form that will put me in a minimally depressed level of consciousness.

__________ d. Intravenous (IV) Sedation/General Anesthetic: Commonly called deep sedation or general, a patient under general anesthetic has no awareness and must have his/her breathing temporarily supported. General anesthesia is appropriate for more invasive procedures.

__________ 6. The use of Nitrous Oxide has been **fully explained to me**, including all risks involved. I have been fully informed that **temporary complications** may include, but are not exclusive of: tingling in the fingers, toes, cheeks, lips, tongue, head or check area; heaviness in the thighs and/or legs, followed by a lighter floating feeling; resonation in the voice or presence of a hypernasal tone; warm feeling throughout body, with flushed cheeks; fits of uncontrollable laughter or giddiness; detachment or disassociation from environment may occur; intense and uncomfortable warm and/or hot feeling throughout body; lightweight or floating sensation with an accompanying "out of body" sensation; sluggishness in motion and slurring and/or repetition of words; feeling of nausea; vomiting; agitation; and/or hallucination. **All of these complications are temporary**.

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__________ 7. **I have had the opportunity to discuss the Nitrous Oxide in conjunction with my dental care, and have had an opportunity to ask questions, and am fully satisfied with the answers I received.**

__________ 8. I accept and understand that I must follow all recommended instructions.

__________ 9. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history involving lung, respiratory, ear infection or common cold. I also accept and understand that I must notify the doctor of my present mental and physical condition.

__________ 10. I accept and understand that I must notify the doctor if I: (1) am pregnant, (2) have sensitivity to any medication, (3) have recently consumed alcohol, and/or (4) am presently on psychiatric mood altering drugs or other medications.

Patient's Signature (or Parent/Guardian): ___________________________________ Date: _________________

Patient's (or Parent/Guardian's) Identification: ____

Witness' Name: ______________________ Witness' Signature: _____________________ Date:____________

CONSCIOUS SEDATION
INFORMED CONSENT FORM

The purpose of this document is to provide an opportunity for patients to understand and give permission for conscious sedation when provided along with dental treatment. Each item should be checked off after the patient has the opportunity for discussion and questions.

_________ 1. I understand that the purpose of conscious sedation is to more comfortably receive necessary care. Conscious sedation is not required to provide the necessary dental care. I understand that conscious sedation has limitations and risks and absolute success cannot be guaranteed. (See #4 options.)

_________ 2. I understand that conscious sedation is a drug-induced state of reduced awareness and decreased ability to respond. Conscious sedation 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 ______ minutes before my appointment. The sedation will last approximately ______ to ______ hours.

_________ 4. I understand that the alternatives to conscious sedation are:

_________ a. No sedation: The necessary procedure is performed under local anesthetic with the patient fully aware.

_________ b. Anxiolysis: Taking a pill to reduce fear and anxiety.

_________ c. Nitrous oxide sedation: Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally aware of surrounding activities. Its effects can be reversed in five minutes with oxygen.

_________ d. Intravenous Administration: The doctor could inject the sedative in a tube connected to a vein in my arm.

_________ d. General Anesthetic: Commonly 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 3 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.

_________ 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 conscious sedation 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 other 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 conscious sedation in conjunction with my dental care.

______________________________ Patient / Guardian

______________ Date

______________ Witness

Your appointment is scheduled for: __________________.

Below are a few important instructions and reminders:

- You should not drink any alcohol or caffeinated beverages for 24 hours prior to your appointment.
- You should also not eat or drink anything for 6 hours before **nor should you take any medication not approved by Doctor** prior to your appointment**.**
- You should not drink grapefruit juice or eat any grapefruit product for 7 days before your appointment.
- At ______ take your sedation pill.
- Have your companion bring you to our office at ______ sharp.
- Absolutely **NO** driving yourself!
- We suggest you wear comfortable clothing e.g. a lightweight jogging suit.

We know the timing may be complicated, but I assure you it is very important.

Also, we have found that many patients benefit from natural healing agents that can be purchased at local drug stores. Vitamin C (1000mg taken 3 x a day) and Enzyme Co Q 10 (50mg taken 2 x a day) will boost your system and aid in producing an excellent healing experience. We recommend beginning this vitamin regimen as soon as 1 week before the appointment and to continue for at least 2 weeks after the appointment.

If you have any questions or concerns, please feel free to call me at (770) 977-3977.

Sincerely,

The Team at Dr. Akbar's Office

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