Wyoming Oral and Maxillofacial Surgery

Anesthesia Consent - WYOMS

DATE	AGE	SEX	HEIGHT	WEIGHT

PROCEDURE(S) ____________________

ALLERGIES TO MEDICATION NKDA ____________________

HAVE YOU HAD PREVIOUS OPERATIONS OR HOSPITALIZATIONS? ____________________

HEALTH HISTORY

▯ YES ▯ NO HIGH BLOOD PRESSURE OR STROKE?
▯ YES ▯ NO DIABETES?
▯ YES ▯ NO SEIZURES? (Epilepsy, Convulsions)
▯ YES ▯ NO LUNG DISEASE? (Asthma, Sleep Apnea)
▯ YES ▯ NO HEART CONDITIONS? (Angina, MI, CHF)
▯ YES ▯ NO LIVER PROBLEMS? (Jaundice, Hepatitis)
▯ YES ▯ NO BLOOD CLOTS OR ABNORMAL BLEEDING?
▯ YES ▯ NO THYROID PROBLEMS?
▯ YES ▯ NO ARTHRITIS?
▯ YES ▯ NO MUSCLE DISORDERS?
▯ YES ▯ NO SKIN DISORDERS?
▯ YES ▯ NO MENTAL HEALTH ISSUES /PHOBIAS?
▯ YES ▯ NO HAVE YOU HAD A VIRUS, COLD, FEVER, OR COUGH WITHIN THE LAST WEEK?
▯YES ▯ NO ARE YOU TAKING BLOOD THINNERS?
▯ YES ▯ NO ARE YOU TAKING BETA BLOCKERS?
▯ YES ▯ NO ACID REFLUX?
▯ YES ▯ NO HISTORY OF MRSA? ACTIVE?
▯ YES ▯ NO OTHER MEDICAL ISSUES? (List Below)

▯ YES ▯ NO IS THERE A POSSIBILITY YOU MAY BE PREGNANT?
▯ YES ▯ NO HAVE YOU OR A BLOOD RELATIVE HAD A NEGATIVE REACTION TO ANESTHESIA?
IF YES, EXPLAIN:____________________
▯ YES ▯ NO DO YOU SMOKE? IF YES, QUANTITY PER DAY: _____
▯ YES ▯ NO DO YOU CONSUME ALCOHOL? HOW OFTEN? ____________________
▯ YES ▯ NO DO YOU HAVE A HISTORY OF ADDICTION OR SUBSTANCE ABUSE?
PATIENT WEIGHT:____________________

DO YOU HAVE ANY OF THE FOLLOWING:
▯ REMOVABLE DENTAL WORK
▯ LOOSE TEETH ▯ CAPPED OR CROWNED TEETH
▯ CHIPPED TEETH
(PEDIATRIC PATIENTS)
▯ YES ▯ NO PREMATURE DELIVERY
▯ YES ▯ NO HX OF APNEA (BREATH HOLDING)

FOR PHYSICIAN USE ONLY

Airway/Teeth/Physical Exam ____________________
Fluids/NPO____________________
V.S. ____________________
Medications Reviewed YES NO
Labs Reviewed: EKG HCG CBC CMPPT/INR Other ____________________**N/A**
Risk/ASA: I II III IV ____________________
Anesthesia Type: General TIVA Epidural Peripheral Block ____________________
Procedure and risks discussed. Questions answered____________________
Comment____________________

I understand that anesthesia involves risks and hazards and I hereby request administration of anesthesia for the relief and protection from pain during planned and/or additional procedures. I understand the anesthesia medication may require change or substitution without prior notification.
I understand that certain uncommon complications may result from the use of any anesthetic drug including; drug reaction; respiratory, central nervous system, or brain damage; and in rare instances, death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to the vocal cords, teeth, eyes or awareness. I understand risks or hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

PATIENT SIGNATURE ____________________Date/Time____________________

PHYSICIAN'S SIGNATURE ____________________Date/Time____________________