HANANESTHESIOLOGY

Medical History Verification Questionnaire

Dear Physician,

The patient named below is scheduled for an elective anesthesia in a non-hospital environment. We would like some information regarding the patient's medical history for anesthetic planning. Please complete this form and send it to us via one of the following methods:

- Email: office@hananesthesiology.com
- Fax: 214-614-7484
- HIPAA Compliant Web Portal: www.hananesthesiology.com under "Submit Document"

*Patient Name*_____ *Patient DOB*_____

Dental Practice Name / City / State _____

1. When did you last examine this patient? _____

2. At the time of the patient's last visit, did he/she have any of the following conditions?

- ☐ Pulmonary Hypertension***
- ☐ A-Fib on RVR, V-Tach, Heart blocks, Prolonged QT, or any other types of abnormal heart rhythm*
- ☐ CHF, even if mild*
- ☐ Uncontrolled HTN (Systolic > 180 OR Diastolic > 100)**
- ☐ Moderately or significantly increased risk of MACE compared to the general public**
- ☐ COPD or Emphysema*
- ☐ Asthma* (more severe than mild intermittent or mild persistent)
- ☐ Asthma requiring oral medications for treatment*
- ☐ BMI > 35*
- ☐ BMI > 40 ***
- ☐ Diabetes **. Please indicate recent A1c and date, if known: _____
- ☐ Any conditions requiring blood thinners.** Please describe:_____

* General Anesthesia Contraindicated

** Requires further workup

*** Conscious Sedation ONLY

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3. At the time of the patient's last visit, did the patient have any other serious medical conditions that the anesthesiologist should know about?

   ☐ No

   ☐ Yes, please describe: _____

   ☐ I can't say

4. Have you, or have you considered referring this patient to a specialist, such as a cardiologist, pulmonologist, etc.?

   ☐ No

   ☐ Yes, please explain: _____

5. **Please attach** any recent visit notes, diagnostics, and labs. Please also provide any additional comments:

Physician Attestation

(Please note that we are not asking for a medical clearance at this time. We will contact you if we need one)

Physician Name: _____

Signature: _____ Date: _____

Notes to the patient's dental office:

- This form must be received no later than three days prior to the appointment date.
- If the "Dental Practice Name" is not written on top of this form, we will NOT be able to identify the patient. So, please be sure to write it before you give this form to your patient.
- DO NOT retain physical copies of this form as it may become outdated. Always obtain the form directly from www.hananesthesiology.com