

DREAM TEAM ORAL SURGERY AND IMPLANT SPECIALTY GROUP

**Department of Anesthesia
Preoperative Patient History**

1829 Jo Johnston Ave.
Nashville, TN 37203
(615) 327-9944

	YES	NO	UNSURE
16. Do you have trouble opening your mouth or have TMJ syndrome?			
17. Have you ever had:			
a. Epilepsy?			
b. Brain tumor?			
c. Brain surgery?			
18. Do you currently take any of the following medications:			
a. Aspirin or other inflammatory medicines?			
b. Blood thinning medicine?			
c. Heart rhythm medicines?			
d. Diuretics or water pills?			
e. Blood pressure pills (anti-hypertensive drugs)?			
f. Heart pills such as Lenoxin or Nitroglycerin?			
g. Steroids?			
19. Do you currently take or have you ever taken the dietary pill Redux or Phen Fen?			
20. Do you take medications? If YES, specify.			
21. Do you have any allergies to medications? If YES, specify.			
22. Are you allergic to eggs, soy, or glycerol? If YES, specify.			
23. Have you or any blood relatives had problems related to an operation or anesthesia?			
24. Do you have any artificial joints, prosthesis, or heart valves? If YES, specify.			
25. What operations have you had?			
26. When were you last in the hospital? Where? What for?			
27. Have you ever had any type of corrective eye surgery? If YES, specify.			
28. Who is your primary care physician (PCP)?			
When did you last see him/her? Where is his/her office?			
29. Do you have any questions or comments?			
30. Do you currently have a living will?			

Signature of person completing form: _____ **Relationship to Patient:** _____