PLEASE ANSWER EACH QUESTION

PATIENT'S NAME_____**AGE**_____

(PLEASE PRINT)

ADDRESS_____

CITY_____**ZIP CODE**_____**PHONE** _____

	CHECK ONE YES	NO
1. Have you been hospitalized for any reason within the last 3 years? If "Yes" please explain_____	____	____
2. Are you presently or have you been within the last 3 years under the care of a physician? If "Yes" please explain_____	____	____
3. Have you taken any kind of medication or drugs during the past year or currently? If "Yes" please explain_____ (This would include oral contraceptives "the pill" also)	____	____
4. Are you allergic to penicillin or any medications or drugs that you know of?	____	____
5. If you've ever been cut have you ever had trouble clotting or in stopping the wound from bleeding?	____	____
6. Do you have or have you ever been diagnosed with any of the following: (Please Circle all that apply) Heart trouble, Heart murmur, hypertension (high blood pressure), hypotension (low blood pressure), Fainting spells, Rheumatic fever, Asthma, Excessive coughing, Diabetes, Tuberculosis, Hepatitis, Jaundice, Arthritis, Stroke		
7. Have you ever suffered or do you have any other serious illness not listed above? Please explain_____	____	____
8. Have you received Pre and Post-Op Instructions?	____	____
9. (Women) Is there any chance that you may be pregnant?	____	____
10. Are you wearing contact lenses	____	____
11. Do you have someone who can drive you home and remain with you while you recover from the affects of the medication?	____	____
12. I state that I read and write English.	____	____

I, the undersigned, give Dr. Michael Grizzaffi permission to administer Intravenous sedation while I undergo my dental procedure(s).

DATE_____Signature_____

REVIEWED BY_____IF PATIENT IS A MINOR, TITLE OR RELATIONSHIP _____