HANANESTHESIOLOGY

Medical History Verification

Directions for the Dental Office:

1. *Please complete the information below and send it to the patient's physician's office.*

   *Patient Name*_____ *Patient DOB*_____

   *Dental Practice Name*_____

   *Dental Office Email Address*_____

   Dental Office Fax _____

2. *Please note that the rest of this form is for the physician's (medical doctor's) office and NOT for the dental office.*
3. *When you receive it back from the physician's office, please send it to us by going to www.hananesthesiology.com and clicking "submit documents"*
4. *Patients who have not visited their physician within 12 months prior to the appointment date will need a medical clearance.*

*Please note that this form must be received **within 3 days prior** to the patient's appointment*

Dear Physician,

The patient named above is scheduled for an elective general anesthesia in an **office environment**. We are requesting a verification of the patient's medical history. Please complete this form and return it to the patient's dental office.

Please note that these are questions regarding the patient's HISTORY only. If we need a medical clearance or an H&P, we will let you know.

1. When was the patient's last visit at your practice? _____

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

- ☐ Pulmonary Hypertension, or even a mildly elevated RVSP
- ☐ 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 (other than mild intermittent or mild persistent)
- ☐ Asthma requiring oral medications for treatment
- ☐ BMI > 35

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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

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

Physician Name: _____

Signature: _____ Date: _____