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General Anesthesia-Important Facts (Adults)

It is common for many patients to feel nervous or anxious about their dental procedures. Your dental anesthesiologist has had advanced training to help with your anxiety by administering medications to make you feel more comfortable. By having a more relaxed patient, your dentist may be able to complete more of your dentistry in one appointment. Anesthesia/sedation is also an excellent option for people that have severe gag reflexes, require extensive dental work, and long or uncomfortable appointments. This information sheet will address the most commonly asked questions regarding anesthesia

What is Sedation and Anesthesia?

The anxiety that some people have can be controlled by administering sedative drugs. A combination of drugs can provide relaxation, amnesia, additional pain control, and even deep sleep. Depending on the patient and the procedure, an anesthetic plan is prescribed that is tailored specifically to meet your needs.

How is the Medication Administered?

The sedative and anesthetic medications are typically given intravenously (IV). Since the effects are so rapid by this means of administration, your anesthesiologist can precisely give the correct amounts of the medications to make you relaxed and comfortable. Also, if more medications are needed during the procedure, the IV allows easy administration of additional medications.

How am I Monitored During the Procedure?

All of your vital signs such as blood pressure, heart rate, respiratory rate, oxygen saturation and EKG are monitored closely during the entire procedure by your dental anesthesiologist. The use of sedation and anesthesia in dentistry has a commendable record of safety. This is due to the advanced training of your anesthesiologist and his commitment to your overall health. It is important to advise your doctor of all medications that you take as well as any changes in your health since your last visit.

Will I need to see or speak with the anesthetist before my sedation appointment?

A review of your medical history will be conducted by telephone, followed by a brief physical exam on the day of the procedure. All of your anxieties and concerns are addressed at this time so that a specific anesthetic plan is formulated to suit your needs. Additional information may also be needed from your physician prior to your anesthesia appointment. Some patients with hypertension, heart disease, asthma, lung

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disease, obesity, sleep apnea and other medical conditions may not be suitable candidates for anesthesia in a dental office.

How much will it cost?

The anesthesia fee is based on the time required for induction, completion of dental work and one hour of recovery. Units are based on the dentists operating time (one unit is equivalent to 15 minutes). The medications that are administered are all short acting and so you will be awake shortly after the dental work is complete. However, you will be continued to be monitored for an additional 30-60 minutes to ensure that you can be safely discharged. An estimate of the duration of the procedure and the fee is given to the patient prior to the sedation appointment. Payment accepted includes Visa, Mastercard, Amex, debit, or cash. Personal cheques are NOT accepted. Payment in full is required on the day of the procedure.

Pre Operative Instructions

- Come to your appointment with a responsible adult who can drive you home. The sedation appointment will not start without an escort.
- Nothing to eat eight hours prior to your appointment. Nothing to drink four hours before your appointment.
- Clear fluids are allowed up to 4 hours before your appointment (e.g. water, juice without pulp, black coffee).
- Take medications as directed by your anesthetist
- Wear loose comfortable clothing. Short sleeves allow monitor and IV placement
- Do not wear jewelry or contact lenses
- Do not wear sandals or slippers
- Do not wear nail polish
- Use the bathroom before your appointment

Post Operative Instructions

- Get plenty of rest
- Drink plenty of fluids
- Avoid strenuous activity
- Avoid alcohol or other sedative medications for 24 hours
- Do not drive or operate heavy machinery for 24 hours
- Do not make important decisions
- Eat light, easily digested foods

Please contact Dr. Lok at 647-225-8871 or email him at office@mobileanaesthesia.com if you have any questions or concerns.

Pre-Anaesthesia Patient Questionnaire (Adult)

32 Davenport Road |Toronto, ON | M5R 0B5

Name: _____

Date of Birth: _____

Current Date: _____

Patient Information	☑ Yes	☑ No	☑ Not Sure
1. Does you currently have any health problems or concerns? Please explain:	☐	☐	☐
2. Has there been ANY change in your general health in the past year? When did you last have a complete physical exam? (Month) _____(Year) _____	☐	☐	☐
3. Have you ever been in hospital for treatment? When, where and why?	☐	☐	☐
4. Has you ever had general anaesthesia or surgery? When, where and why? Were there any problems with the anaesthesia?	☐	☐	☐
5. Have you or any of your family relatives had problems with anaesthesia? Please explain: Were any tests done?	☐	☐	☐
6. Do you have a drug allergy? What drug? What year? What happened? ☐ Rash ☐ Breathing problems/Wheezing ☐ Swelling	☐	☐	☐
7. Do you have any allergies (e.g. latex)? Please list allergies:	☐	☐	☐
8. Do you take ANY medications right now (including puffers)? Please list or bring a list of all your medications, or bring them to the office (List name and dose):	☐	☐	☐
9. Do you take ANY non-prescription remedies (including herbal remedies)? Name:	☐	☐	☐
10. Have you taken a cortisone (steroid) drug orally in the past year? When? For how long?	☐	☐	☐
11. Do you or any of your relatives have a bleeding problem?	☐	☐	☐
12. Do you have, or have you ever had, any difficulty breathing through your nose?	☐	☐	☐
13. Do you have any nose bleeds? If so, how many per week?	☐	☐	☐
14. Do you have, or have you ever had, any difficulty breathing while sleeping at home?	☐	☐	☐
15. Can you walk up 2 flights of stairs or 2 city blocks quickly without resting?	☐	☐	☐

16. Do you have, or have you ever had, any of the following?

	Yes	No	Not Sure		Yes	No	Not Sure
Heart murmur	☐	☐	☐	Fainting spells, dizziness	☐	☐	☐
Heart attack	☐	☐	☐	Diabetes	☐	☐	☐
Chest pain or angina	☐	☐	☐	Thyroid problems	☐	☐	☐
Shortness of breath lying down	☐	☐	☐	Adrenal gland problems	☐	☐	☐
Swollen ankles	☐	☐	☐	Hepatitis	☐	☐	☐
Heart pacemaker/defibrillator	☐	☐	☐	Liver disease / Jaundice	☐	☐	☐
Irregular heart beat/arrhythmia	☐	☐	☐	Anemia (including sickle cell)	☐	☐	☐
High blood pressure	☐	☐	☐	Blood disorders/transfusions	☐	☐	☐
Congenital heart disease	☐	☐	☐	Bleeding (Coagulation) disorders	☐	☐	☐
Damaged/abnormal heart valves	☐	☐	☐	Stomach ulcers / Acid Reflux	☐	☐	☐
Rheumatic fever	☐	☐	☐	Bone, joint, or muscle problems	☐	☐	☐
Kidney disease	☐	☐	☐	Artificial joints - hips, knees	☐	☐	☐
HIV, AIDS or STD	☐	☐	☐	Arthritis	☐	☐	☐
Malignant hyperthermia	☐	☐	☐	Depression / anxiety	☐	☐	☐
Pseudocholinesterase deficiency	☐	☐	☐	Vision problems / glaucoma	☐	☐	☐
Cancer / Chemotherapy	☐	☐	☐	Mentally disabled	☐	☐	☐
Sleep apnea	☐	☐	☐	Cerebral palsy	☐	☐	☐
Asthma	☐	☐	☐	Autism or Down's Syndrome	☐	☐	☐
Emphysema / Bronchitis	☐	☐	☐				
Cystic fibrosis / Tuberculosis	☐	☐	☐	Are you pregnant?	☐	☐	☐
Epilepsy	☐	☐	☐	Are you a nursing mother?	☐	☐	☐
Stroke	☐	☐	☐	Any problems with menstruation?	☐	☐	☐

17. Do you ever have episodes of blurred vision or black spots, or experience weakness or paralysis on one side of your body, arms, legs, or face? ☐ ☐ ☐
18. Do you have any problems opening your mouth wide or moving your neck fully? ☐ ☐ ☐
19. Have you ever had surgery, radiation or chemotherapy treatment for a tumour or cancer? ☐ ☐ ☐
20. Do you smoke? If so, how much? _____ ☐ ☐ ☐
21. Do you drink more than 5 alcoholic beverages per week? Number per week? _____ ☐ ☐ ☐
22. Do you have a history of alcoholism or drug dependence? ☐ ☐ ☐
23. Have you take any "recreational" drugs in the past year such as marijuana, LSD, PCP, cocaine, crack, crystal meth, codeine, oxycodone, or other drugs? ☐ ☐ ☐
24. Do you have ANY disease, condition or problem not listed above? _____ ☐ ☐ ☐
25. How much do you weigh? _____ Height? _____
26. Additional comments? _____

▶▶▶ I declare that the above information is a true and accurate account of my heath status:

Signature of patient: _____

Date: (MM/DD/YYYY) _____