SOUTH SHORE ORAL SURGERY ASSOCIATES

DR. STEVEN J. VERVENIOTIS | DR. RICHARD M. MIRRA

Anesthesia Questionnaire

PATIENT INFORMATION

First Name		Last Name		Birth Date	

Height		**Weight**		**Age**	
Have you ever had general anesthesia before?				❑ Yes	❑ No
If so, when and for what reason					
Did you experience any negative reaction?				❑ Yes	❑ No
If yes, please describe					
Are you accompanied by someone to drive you home?				❑ Yes	❑ No
If not, whom may we call?				**Phone #**	
When did you last eat or drink anything?					
Do you smoke?				❑ Yes	❑ No
If yes, how much?					
Who is your regular physician?				**Phone #**	
Are you currently taking ANY medications, prescribed or otherwise?				❑ Yes	❑ No
If yes, please list					

FORM COMPLETION

Signature of Patient, Parent or Legal Guardian		Date	

IF PATIENT IS A MINOR

Printed Name		Relationship to Patient	