THAMES RIVER FAMILY DENTISTRY

NITROUS OXIDE – QUESTIONARE

NAME: _____ **DOB:** _____

AGE: _____ **SEX:** **Male** ◯ **Female** ◯

ADDRESS: _____

PHONE NUMBER: _____ **(H)** _____ **(M)**

	YES	NO
1. Are you or do you think you could be PREGNANT? _____		
2. Do you receive injections or infusions as part of your chemotherapy? • Is BLEOMYCIN part of the chemotherapy? _____		
3. Have you ever been treated for BOWEL OBSTRUCTION? _____		
4. Have you had any EAR surgeries in the past 6 months? _____		
5. Have you had any EYE surgeries in the past 6 months? _____		
6. Have you ever seen a heart or lung specialist for PULMONARY HYPERTENSION? • Do you take any medications for pulmonary hypertension? _____ _____		
7. Have you ever had a brain tumor, brain infection, very high blood pressure, or stroke? • Are you experiencing any episodes of headache, blurred vision, fainting, or unusual difficulty with memory? _____		
8. Do you take METHOTREXATE as part of your medication regimen? _____		
9. Do you have FOLIC ACID or vitamin B – 12 deficiency? _____		
10. Do you get carsick often? E.g. nausea, vomiting _____		

Signature: _____ Date: _____