Giggle Gas (Nitrous oxide) Instructions

Please fill out the attached forms. Return 2 days prior to appointment.

No food or drink 3 hours prior to their appointment time. Please bring a clear juice with you so that your child can have it at the end of their appointment.

If you have an early morning appointment and your child weights less than 50lbs please wake them up to feed them 3 hours prior as mentioned above.

In the event of a cold, flu or any allergies where your child is unable to breathe through his or her nose, the treatment will need to be rescheduled as the giggle gas will not be effective.

If your child is having extractions it is best that you do not send them to school for the of the day, however they should be fine to return to school the following day.

Although it is rare that a child has an adverse reaction to the giggle gas, it is best to keep them home from school for the rest of the day if this is the child's first experience with giggle gas.

If your child has had local anesthetic (freezing) be sure that they do not bite their lip or cheek while still frozen. Lip and cheek trauma is the most common injury after freezing and the area may take up to 7-10 days to heal.

If your child had amalgam (silver) Fillings, sticky and chewy foods should be avoided for 24 hours while the filling is setting. This does not apply to composite resin (white) fillings. However white fillings can be temperature sensitive. This may last for a few weeks to a few months.

If there are any questions or complications after your child's appointment call the office at (905)842-0005 fax (905)842-0015

Pre-Anaesthesia Questionnaire (Child) Date of Birth: _____

Name _____ **Date** _____

	Yes	No	Not Sure
1. Does your child have any health problems or concerns presently? Please explain:_____	☐	☐	☐
2. Has there been ANY change in general health in the past year? When did your child last visit their family physician? (month)_____(year)_____	☐	☐	☐
3. Has your child ever been in hospital for treatment? _____ When, where and why? _____	☐	☐	☐
4. Has your child 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. Does your child have a drug allergy? What drug? What year? What happened? (Circle) rash breathing problems/wheezing swelling	☐	☐	☐
7. Does your child have any other allergies (e.g. latex)? _____	☐	☐	☐
8. Does your child take ANY medications right now (including puffers)? Please list: Name Dose	☐	☐	☐
9. Does your child take ANY non-prescription remedies (including herbal remedies)? Name	☐	☐	☐
10. Has your child had a cortisone (steroid) type drug orally in the past year? When? For how long?	☐	☐	☐
11. Has your child taken any medicine for a long time in the past? Name Reason	☐	☐	☐
12. Has your child had aspirin or aspirin containing compounds (ASA, Bufferin, Anacin, 222) within the last week?	☐	☐	☐
13. Does your child or anyone in the family have a bleeding problem?	☐	☐	☐
14. Has your child been exposed to any infectious diseases in the past month?	☐	☐	☐
15. Does your child have any difficulty breathing while sleeping at home?	☐	☐	☐

Pre-Anaesthesia Questionnaire (Child) cont'd

Name_____ **Age** _____

16. Does your child have or ever had any of the following?

	Yes	No	Not Sure		Yes	No	Not Sure
Heart murmur				Croup			
Congenital heart disease				Other lung diseases			
Chest pain or angina				Cancer/Chemotherapy			
Heart pacemaker/defibrillator				Fainting spells, dizziness			
Irregular heart beat/arrhythmia				Thyroid problems			
Damaged/abnormal heart valves				Glaucoma or vision problems			
Rheumatic fever				Muscular dystrophy			
Liver disease / Jaundice				Arthritis			
Hepatitis				Bone, joint or muscle problems			
Blood / Coagulation disorders				Stomach ulcers/Acid reflux			
Anemia (including sickle cell)				Sleep apnea			
Thalassemia				Pseudocholinesterase deficiency			
Kidney disease				Malignant hyperthermia			
Adrenal gland problems				Epilepsy/Seizures/Convulsions			
Diabetes				Cerebral palsy			
HIV, AIDS				Down's syndrome			
Asthma				Autism			
Cystic fibrosis / Tuberculosis				Mentally disabled			

	Yes	No	Not Sure
17. Does your child have any difficulty breathing through their nose?	☐	☐	☐
18. Does your child have any nose bleeds? If so, how many per week?	☐	☐	☐
19. Does your child have problems running around and playing freely?	☐	☐	☐
20. Does your child get short of breath very easily?	☐	☐	☐
21. Does your child ever turn a blue colour and/or faint when trying to run or play?	☐	☐	☐
22. Does your child have any problems opening his/her mouth wide?	☐	☐	☐
23. Does your child have any problems moving his/her neck freely?	☐	☐	☐
24. Has your child ever had surgery and/or radiation treatment for a tumour or cancer?	☐	☐	☐
25. Does your child smoke?	☐	☐	☐
26. If your child is of child bearing age, is she pregnant?	☐	☐	☐
27. Does your child have any loose teeth (especially front teeth)?	☐	☐	☐

28. Does your child have ANY disease, condition or problem not mentioned so far?

29. How much does your child weigh? _____**Height**_____

30. Additional comments: _____

Signature: **Date:**

Relationship: **Parent** **Guardian** **Patient**