Nitrous Record Sheet

Patients Name: _____ Date: _____

Weight: _____ Age: _____

Medical History: _____ DOB: _____

Allergies _____

ASA: _____ Escort Present: Yes No

Pregnant: Yes No Consent: Yes No

Malampatti: I II III IV

Snoring: Yes No Sleep Apnea

Smoker: Yes No

Equipment Checked by: _____

Administered: _____ Settings (Percentages of Gas): _____ Time Started: _____ Time Ended: _____

Vital Signs

	Blood Pressure	Pulse Ox.	Pulse
Pre-op			
Discharge			

Discharge

Time: _____

Written/Verbal Instructions: Y N

Discharge to: _____

Dr. Signature: _____

Assistant: _____