Anesthesia Record

Patient Name: Doe, John "Johnny"
Date: 8/22/2026 **DOB:** 12/24/1982 (age: 43)
Ht: 5 ft 7 in **Wt:** 125 lb **BMI**: 19.6
NPO Status: food: not within 6 hours, drink: not within 2 hours
ASA Classification: 1
Allergies: NKDA
Procedure: Implant 29, 30
Reason For Sedation: Acute Situational Anxiety, Post Traumatic Stress Disorder

Surgeon: Dr. Smart Chart
Office: Demo Office, Operatory #2
Sedation Provider: Dr. Smart Chart
Type of Anesthesia: Moderate
Present: Sarah W. Jamie H., Joe Smith
Responsible Companion: Daughter: Kimberly 509-555-5555

Anesthesia Times

Start: 10:50
End: 11:45
Anesthesia Minutes: 55
Anesthesia Units (15m): 3.7
Recovery Complete: 12:09

Health History/Systems Review:
Non-surgical hospitalization summary: none.
Surgeries: none.
Personal anesthesia history: No known anesthesia complications.
Familial anesthesia history: No known anesthesia complications.
Cardiac System:
HTN: controlled
Endocrine System:
Diabetes: Type 2, 850mg PO bid, 145, 6.1, 120
Hypothyroidism
Other: High Cholesterol, Lipitor 10mg PO qd/diet+exercise

Medications: Lipitor, Metformin, levothyroxine, Hydrochlorothiazide

Medical Consult Notes: Cleared from procedure by Dr. Smith, Cardiology

Physical assessment: Pregnancy: Negative HCG, Breastfeeding: no, Instructed to dispose of expressed milk for next 24 hours, Modified Mallampati: Class II, Lung auscultation: CTAB, Heart auscultation: RRR w/o murmur

Pre-anesthesia risk assessment: Minimal risk associated with moderate sedation for this patient. Airway will be constantly monitored and the patient will be positioned elevated to protect the airway. Patient will be positioned with a slight upright posture.

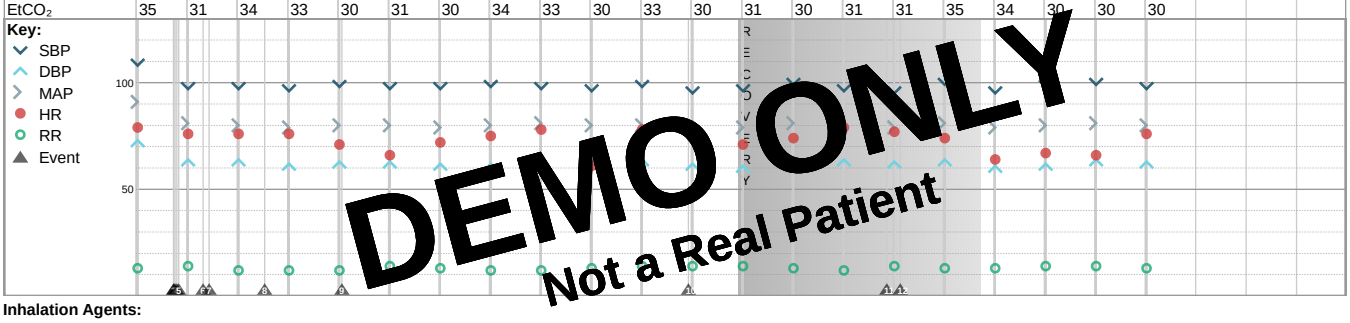
Surgical Timeout: Completed 10:49. • Correct patient identity. • Correct procedure. • Correct site (including site marking, if applicable). • Verification of implants, blood products, X-rays, and required medical devices. • Missing information or discrepancies resolved.

Time:	10:45	10:50	10:55	11:00	11:05	11:10	11:15	11:20	11:25	11:30	11:35	11:40	11:45	11:50	11:55	12:00	12:05	12:10
SpO_2	98	96	96	98	98	96	97	96	96	96	99	96	97	99	96	98	96	99
ECG	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR
$EtCO_2$	35	31	34	33	30	31	30	34	33	30	33	30	31	30	31	31	35	34

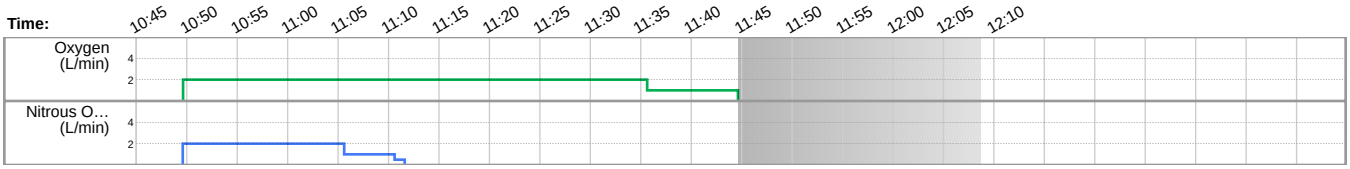
Time:	12:15	12:20	12:25	12:30	12:35	12:40	12:45	12:50	12:55	13:00	13:05	13:10	13:15	13:20	13:25	13:30	13:35	13:40
SpO_2	99	99	96	96														
ECG	NSR	NSR	NSR	NSR														
$EtCO_2$	30	30	30	30														

Initial:
BP: 108/73
SpO_2: 98%

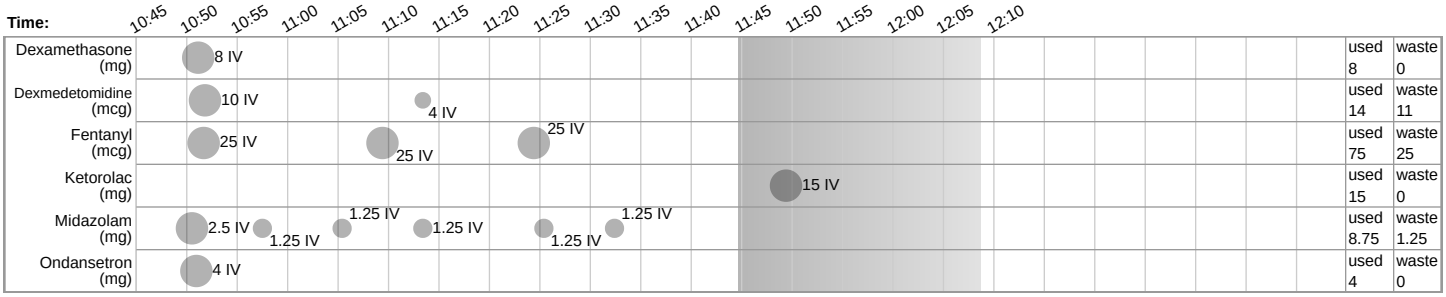
Final:
BP: 97/63
SpO_2: 96%



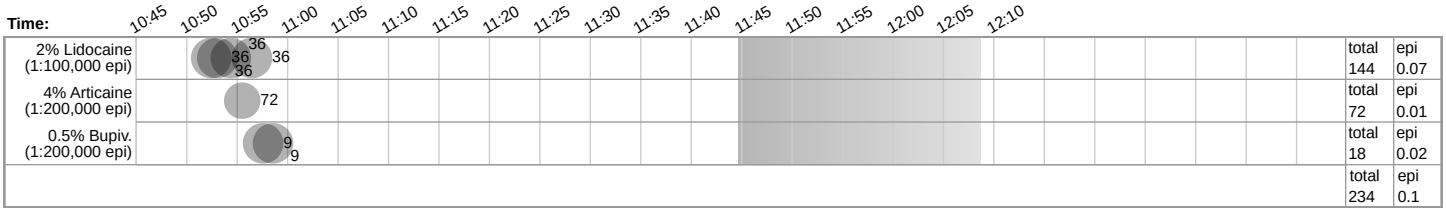
Inhalation Agents:



Parenteral Drugs:



Local Anesthetics:



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Dr. Smart Chart
Case ID: tour_betteranesthesiacharting_nFIEoJ8kNROggR
Patient ID:

Events: ⚠ 10:48: IV placed at the Right Hand ⚠ 10:49: Surgical Timeout ⚠ 10:49: Nasal Cannula Placed ⚠ 10:49: Nasal Hood Placed ⚠ 10:49: Semi Fowler's Position ⚠ 10:51: Extracted four red top vials of blood through IV catheter for PRF placement post third molar extraction. ⚠ 10:52: Throat screen placed ⚠ 10:58: Procedure Started ⚠ 11:05: Nasal Hood Removed ⚠ 11:40: Procedure Ended ⚠ 11:59: Nasal Cannula Removed ⚠ 12:01: IV removed from the Right Hand ⚠ 13:14: Throat screen removed

Pre-procedure Sedatives:
Triazolam: 0.5mg, SL, 09:43

Pre-procedure Medications:
Amoxicillin (Oral Pill): 10:43, 2000 mg, PO
Albuterol (Inhalant): 10:44, 2 puffs, Inhalation

Inhalation Agents (list view):
started on room air
Oxygen: 10:49 2L/min, 11:35 1L/min, 11:44 0L/min
Nitrous Oxide: 10:49 2L/min, 11:05 1L/min, 11:10 0.5L/min, 11:11 0L/min

Parenteral Drugs (list view):
Dexamethasone: 10:51 8mg IV 0.14mg/kg
Dexmedetomidine: 10:51 10mcg IV 0.18mcg/kg, 11:13 4mcg IV 0.07mcg/kg
Fentanyl: 10:51 25mcg IV 0.44mcg/kg, 11:09 25mcg IV 0.44mcg/kg, 11:24 25mcg IV 0.44mcg/kg
Ketorolac: 11:49 15mg IV 0.26mg/kg
Midazolam: 10:50 2.5mg IV 44.1mcg/kg, 10:57 1.25mg IV 22mcg/kg, 11:05 1.25mg IV 22mcg/kg, 11:13 1.25mg IV 22mcg/kg, 11:25 1.25mg IV 22mcg/kg, 11:32 1.25mg IV 22mcg/kg
Ondansetron: 10:50 4mg IV 70.5mcg/kg

Local Anesthetic (list view):
10:52 36mg 2% Lidocaine, 0.018 mg epi.
10:53 36mg 2% Lidocaine, 0.018 mg epi.
10:54 36mg 2% Lidocaine, 0.018 mg epi.
10:55 72mg 4% Articaine, 0.009 mg epi.
10:56 36mg 2% Lidocaine, 0.018 mg epi.
10:57 9mg 0.5% Bupivacaine, 0.009 mg epi.
10:58 9mg 0.5% Bupivacaine, 0.009 mg epi.

IV:
IV Site on Right Hand inserted at 10:48 using 22-gauge needle on first attempt, secured using tape, tegaderm. Removed at 12:01.
Total Fluid Administered: LR: 500 mL
SpO_2 at final IV removal: 98%

Pre-op Checks: ☑ Equipment readiness check ☑ Confirmed correct patient and procedure ☑ Instructions ☑ Reviewed health history ☑ Financial arrangements ☑ Informed consents ☑ Transportation arranged ☑ Bathroom ☑ Reviewed vitals ☑ Answered all questions ☑ Made comfortable ☑ Offered blanket/pillow ☑ Pressure points relieved **Additional Measures:** ☑ Sequential compression device ☑ Knee support pillow

Airway:
Nasal Cannula – placed 10:49, removed 11:59, in use for 1h 10m 32s
Nasal Hood – placed 10:49, removed 11:05, in use for 16m 21s

Position: Semi Fowler's: 10:49

Aldrete Score:

Vital signs: within 14% of preoperative value	2
Oxygenation:	2
Respiratory Stability:	2
Consciousness:	2
Post Operative Pain:	2
Nausea and Vomiting:	2
Gait:	1

Total Score: 13

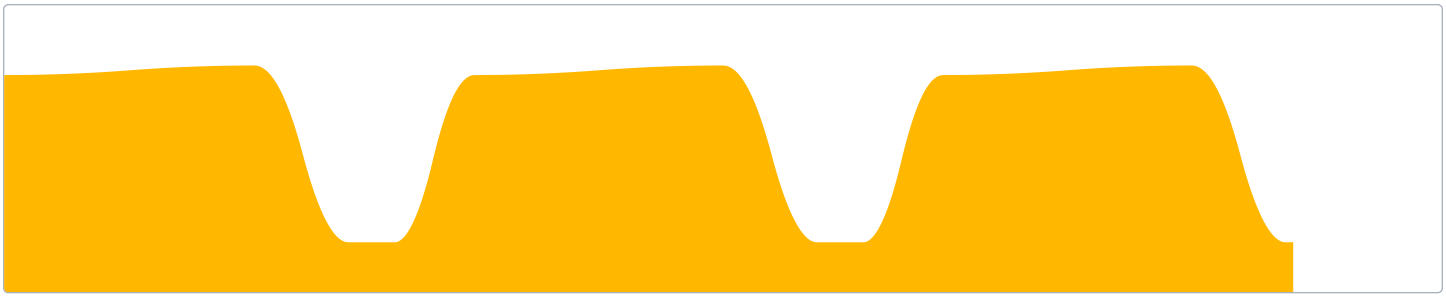
DEMO ONLY
Not a Real Patient

Notes: The tooth was sectioned, and each fragment was precisely removed. Patient signed consents forms on DOS prior to appointment. Reviewed HHx/Systems. Titrated sedatives to desired effect. No complications encountered with sedation or surgical procedure. Patient self maintained airway with no obstructive events throughout the case. Patient remained hemodynamically stable throughout case.

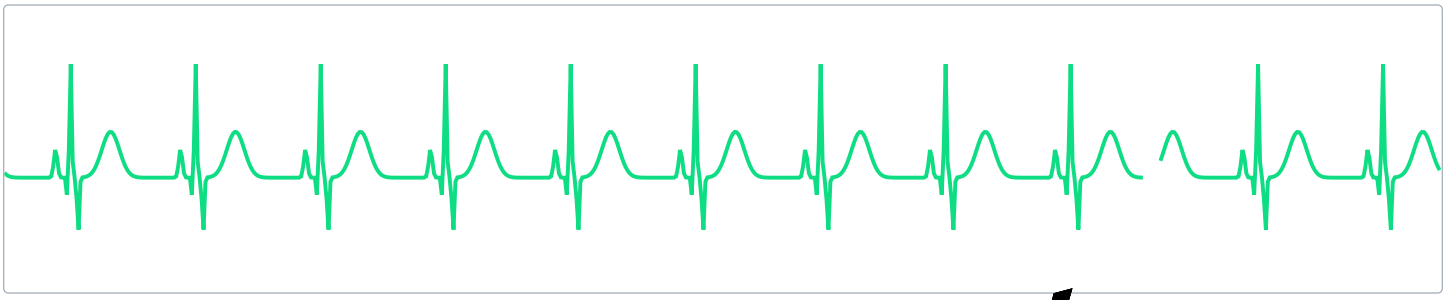
Recovery Notes: Patient recovered in recovery bay PSCU by Jamie H. Spontaneous recovery with no requirement for reversals or stimulation. No complications encountered. Patient is able to maintain own vitals without stimulation and on room air. Post op instructions administered oral and written to RC. Patient self ambulated to wheelchair. ER contact information administered to the RC. RC sent copy of Post Op info. RC signed Post Op info sheet.

Captured Waveforms

$EtCO_2$ captured: 8/22/2026 10:45:41



ECG II captured: 8/22/2026 10:45:41



Pleth captured: 8/22/2026 10:45:41



Vitals Data Reference

Time	SBP	DBP	MAP	HR	SpO_2	ECG	RR	$EtCO_2$
10:45	108	73	91	79	98	NSR	13	35
10:50	97	64	81	76	96	NSR	14	31
10:55	97	64	80	76	96	NSR	12	34
11:00	96	62	79	76	98	NSR	12	33
11:05	98	63	80	71	98	NSR	12	30
11:10	97	63	80	66	96	NSR	14	31
11:15	97	62	79	72	97	NSR	13	30
11:20	98	62	80	75	96	NSR	12	34
11:25	97	64	81	78	96	NSR	12	33
11:30	96	63	80	61	96	NSR	13	30
11:35	98	64	80	78	99	NSR	14	33
11:40	95	62	79	74	96	NSR	14	30
11:45	96	61	79	71	97	NSR	14	31
11:50	99	64	81	74	99	NSR	13	30
11:55	96	64	80	79	96	NSR	12	31
12:00	95	63	79	77	98	NSR	14	31
12:05	99	64	81	74	96	NSR	13	35
12:10	95	61	79	64	99	NSR	13	34
12:15	98	62	80	67	99	NSR	14	30
12:20	99	64	81	66	96	NSR	14	30
12:25	97	63	80	76	96	NSR	13	31

DEMO ONLY
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Preoperative Sedation/Anesthesia Checklist

Patient Name: Doe, John "Johnny"
Date of Birth: 12/24/1982 (age: 43)
Procedure: Implant 29, 30
Type of Anesthesia: Moderate
Reason for sedation: Acute Situational Anxiety, Post Traumatic Stress Disorder

History

- [x] **Patient medical history:**
  Cardiac System:
  HTN: controlled
  Endocrine System:
  Diabetes: Type 2, 850mg PO bid, 145, 6.1, 120
  Hypothyroidism
  Other: High Cholesterol, Lipitor 10mg PO qd/diet+exercise
- [x] **Allergies:** NKDA
- [x] **Surgical History:** none
- [x] **Anesthesia History:** No known anesthesia complications
- [x] **Family Anesthesia History:** No known anesthesia complications
- [x] **Medications:** Lipitor, Metformin, levothyroxine, Hydrochlorothiazide

Other Preoperative Checks

- [x] Equipment readiness check
- [x] Confirmed correct patient and procedure
- [x] Instructions
- [x] Reviewed health history
- [x] Financial arrangements
- [x] Informed consents
- [x] Transportation arranged
- [x] Bathroom
- [x] Reviewed vitals
- [x] Answered all questions
- [x] Made comfortable
- [x] Offered blanket/pillow
- [x] Pressure points relieved

Physical Examination

- [x] **Height:** 5 ft 7 in
- [x] **Weight:** 125 lb
- [x] **BMI**: 19.6
- [x] **ASA Classification:** 1
- [x] **NPO Status:** food: not within 6 hours, drink: not within 2 hours
- [x] **Initial Vitals:** BP: 108/73, SpO_2: 98%, RR: 12, HR: 79

Anesthesia-Specific Physical Exam

- [x] **Lung Auscultation:** CTAB
- [x] **Heart Auscultation:** RRR, no murmur
- [x] **Modified Mallampati:** Class I

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Additional Pre-Anesthesia Risk Assessment Notes

Minimal risk associated with moderate sedation for this patient. Airway will be constantly monitored and the patient will be positioned elevated to protect the airway. Patient will be positioned with a slight upright posture.

Medical Consult Notes

Cleared from procedure by Dr. Smith, Cardiology