PLEASE COMPLETE THIS FORM PRIOR TO YOUR PRE-ANESTHETIC EVALUATION

I AGREE TO HAVE NOTHING BY MOUTH AFTER MIDNIGHT THE NIGHT BEFORE MY SURGERY UNLESS INSTRUCTED TO DO SO.

Height_____ Weight_____ Age_____

Allergies (Medication, Latex, Food, Other) _____

YES_____ NO_____ Is this your first anesthetic?

YES_____ NO_____ Have you ever had problems with anesthesia? Specify _____

YES_____ NO_____ Have members of your family had problems with anesthesia? Specify_____

YES_____ NO_____ If female, date of last menstrual period? (If menopausal include year of last period)_____

YES_____ NO_____ Are you or could you be pregnant?

YES_____ NO_____ Are you currently taking any prescription/over-the-counter medications, herbal, and/or dietary supplements; list medication & dosage_____

_____

_____

DO YOU HAVE OR HAVE YOU HAD:

YES_____ NO_____ Heart disease (including: heart murmur, pacemaker, catheterization, stents, surgery, mitral valve prolapse) Specify _____

YES_____ NO_____ Chest pain Do you exercise regularly? YES_____ NO_____ What type _____

YES_____ NO_____ Previous EKG/stress test/echocardiogram Date(s) _____

YES_____ NO_____ High blood pressure

YES_____ NO_____ Asthma Hospitalizations YES_____ NO_____ how many_____

YES_____ NO_____ Lung disease Specify _____

YES_____ NO_____ Chronic cough

YES_____ NO_____ Shortness of breath

YES_____ NO_____ Sleep apnea CPAP YES_____ NO_____

YES_____ NO_____ Abnormal chest x-ray

YES_____ NO_____ Kidney disease Specify_____ Difficulty voiding YES_____ NO_____

YES_____ NO_____ Liver disease/Hepatitis/Jaundice Specify _____

YES_____ NO_____ Diabetes Year diagnosed_____ Do you take insulin? YES_____ NO_____

YES_____ NO_____ Are you on a special diet? Specify _____

YES_____ NO_____ Recent weight loss how much _____

YES_____ NO_____ Epilepsy/Seizures/Stroke/Neurological problems Specify_____

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Pre-Anesthetic Questionnaire

Patient Information/Label

YES_____ NO_____ Autoimmune disorders/Connective tissue disorders/Lupus/Sarcoid Specify _____

YES_____ NO_____ Psychological conditions (depression, anxiety, bipolar disorder, schizophrenia, etc.) Specify _____

YES_____ NO_____ Thyroid or goiter problems Specify _____

YES_____ NO_____ Bowel/colon disease or problems Specify _____

YES_____ NO_____ Frequent heartburn/indigestion, esophageal reflux, hiatal hernia

YES_____ NO_____ Glaucoma Use eye drops YES_____ NO_____

YES_____ NO_____ Back and/or neck problems Specify _____

YES_____ NO_____ Muscle weakness Specify _____

YES_____ NO_____ Metal implants (back, hip, knee, etc) Specify _____

YES_____ NO_____ Past/present carrier of contagious/infectious disease Specify _____

YES_____ NO_____ Exposure to communicable diseases in the past 3 weeks Specify _____

YES_____ NO_____ Bleeding or clotting abnormalities Specify _____

YES_____ NO_____ History of blood transfusions Specify _____

YES_____ NO_____ Nose surgery

YES_____ NO_____ Broken bones in face, back or neck Specify _____

YES_____ NO_____ Do you or have you ever smoked? amount per day_____ how many years_____ year quit _____

Use(d) smokeless tobacco how many years_____ year quit_____

Use(d) recreational drugs type(s)_____ how much_____ how many years _____

Use alcohol type(s)_____ how much_____

Been treated for substance abuse type(s)_____ when _____

YES_____ NO_____ Steroid use in the past 12 months Specify _____

DO YOU HAVE ANY OF THE FOLLOWING?

Dentures_____ Partial plate_____ Bridgework-permanent_____ Caps/Crowns_____ Chipped/Missing teeth_____

ARE YOU WEARING ANY OF THE FOLLOWING?

Contact lens_____ False eyelashes_____ Wig/hairpiece_____ Hearing aid_____

LIST ADDITIONAL MEDICAL/SURGICAL PROBLEMS: _____

_____

LIST PREVIOUS SURGERIES: _____

_____

PATIENT SIGNATURE	PARENT, GUARDIAN, OR NEXT OF KIN (if patient. unable to sign)	RELATIONSHIP

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PRE-ANESTHETIC EVALUATION

ALLERGIES/SENSITIVITIES: ☐ NKDA ☐ ANTIBIOTICS ☐ NARCOTICS ☐ OTHER (food, Iodine, Tape, Etc.)
List:

Temp_____ B/P_____ Pulse_____ Resp_____ SaO2 _____
Any Lab/EKG/x-ray being obtained from other facility ☐ YES ☐ NO
If yes, where: _____
Pre-Operative teaching done? ☐ YES ☐ NO _____RN/LPN & Date
Patient verbalized understanding? ☐ YES ☐ NO COMMENTS: _____

TYPE OF ANESTHESIA DISCUSSED WITH PATIENT

☐ GENERAL ☐ TIVA/MAC ☐ SPINAL ☐ EPIDURAL ☐ IV BLOCK ☐ PERIPHERAL NERVE BLOCK

PROBLEMS: 1._____ **2.**_____ **3.** _____

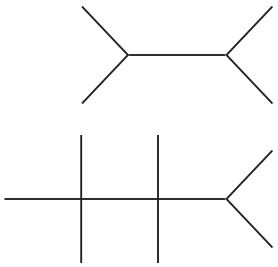
4._____ **5.**_____ **6.** _____

AIRWAY EXAM: MP I II III IV
☐ TMD > 3 FB ☐ FROM **DENTITION** ☐ INTACT ☐ CROWNS
CHEST: ☐ CTA ☐ CHIPPED ☐ DENTURES
☐ **CXR** ☐ LOOSE ☐ PERIDONTAL DISEASE
☐ **PFT's**
HEART: ☐ RRR

☐ **ECHO**
☐ **STRESS TEST**
☐ **EKG INTERPRETATION**

ASA RISK STATUS: 1 2 3 4 5 E

Labs/Studies:



PT_____ bHCG _____
PTT_____ GLUCOSE _____
INR_____

RECOMMENDATIONS: _____

I HAVE REVIEWED PATIENT QUESTIONNAIRE AND ASSESSMENT FOR ABNORMALITIES: ☐ YES
PATIENT HAS RECEIVED INFORMATION ON PAIN MANAGEMENT: ☐ YES
PATIENT IS CANDIDATE FOR: ☐ P.C.A. PUMP
☐ POST SURGICAL EPIDURAL ☐ PERIPHERAL NERVE BLOCK

Date:_____ ***Time:***_____ _____**N.P. / M.D.**
Signature

ASSESSMENT PRIOR TO SURGERY

Date:_____ ***Time:***_____ _____**M.D.**
Signature

PATIENT SEEN POST-OP ☐ NO AWARENESS ☐ COMFORTABLE (PAIN <4) ☐ AWAKE, ALERT, ORIENTED
☐ STABLE PATENT AIRWAY ☐ IV FLUID CONTINUES/PATIENT IS WELL HYDRATED
COMPLICATIONS: ☐ NONE ☐ OTHER_____ ☐ PATIENT CLEARED FOR DISCHARGE
Date:_____ ***Time:***_____ _____**N.P. / M.D.**
Signature

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