

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?
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
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

PRE-ANESTHETIC EVALUATION
ALLERGIES/SENSITIVITIES: NKDA ANTIBIOTICS NARCOTICS OTHER (food, Iodine, Tape, Etc.)
List

1.
2.

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
Patient verbalized understanding YES NO
RN/LPN & Date _____

COMMENTS:

ASSESSMENT:

HEAD/NECK:

CHEST:

HEART:

ABNORMAL LAB/X-RAY/EKG FINDING:

ASA RISK STATUS: 1 2 3 4 5 E

RECOMMENDATIONS:

HAVE REVIEWED PATIENT QUESTIONNAIRE AND ASSESSMENT FOR ABNORMALITIES:

YES NO

PATIENT RECEIVED INFORMATION ON PAIN MANAGEMENT

YES NO

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

Signature

ASSESSMENT PRIOR TO SURGERY

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