PRE-ANESTHESIA EVALUATION

Please Bring Completed Form DAY OF SURGERY

DATE _____

PHYSICAL

Age: _____ Height: _____ Weight: _____

MEDICAL HISTORY QUESTIONNAIRE

Yes No

- ☐ ☐ Do you have a heart condition?
- ☐ ☐ Have you had a heart attack? When? _____
- ☐ ☐ Have you had chest pain? How often? _____
- ☐ ☐ Do you have irregular heartbeat?
- ☐ ☐ Do you have high blood pressure?
- ☐ ☐ Have you ever had a stroke? When? _____
- ☐ ☐ Do you have asthma, bronchitis, or any other breathing problem?
- ☐ ☐ Do you experience shortness of breath?
- ☐ ☐ Do you (or did you) smoke?
- ☐ ☐ Packs/day: _____ Number of years: _____ Date you quit? _____
- ☐ ☐ Have you recently had a cold or flu?
- ☐ ☐ Do you have neck pain?
- ☐ ☐ Do you have any jaw problems?
- ☐ ☐ Do you have loose, chipped, false teeth, or bridgework?
- ☐ ☐ Do you have diabetes?
- ☐ ☐ Do you have a thyroid condition?
- ☐ ☐ Do you have or have had kidney disease?
- ☐ ☐ Have you had hepatitis, liver disease, or jaundice?
- ☐ ☐ Do you have any reflux disease, heart burn, reflux or GERD?
- ☐ ☐ Do you have ulcers or other stomach disorders?
- ☐ ☐ Do you have hiatal hernia?
- ☐ ☐ Do you have bleeding problems?
- ☐ ☐ Do you or any of your family have sickle cell trait?
- ☐ ☐ Do you have numbness, weakness, or paralysis of your extremities?
- ☐ ☐ Do you have any muscle or nerve disease?
- ☐ ☐ Have you ever had a seizure?
  How often? _____ Last seizure: _____
- ☐ ☐ Do you have back pain or arthritis?
- ☐ ☐ Do you consume alcohol? Drinks per week: _____
- ☐ ☐ Do you take or have you taken recreational drugs?
- ☐ ☐ Do you wear contact lenses?
- ☐ ☐ Have you or any blood relative had difficulties with anesthesia?
- ☐ ☐ Have you had any nausea/vomiting with anesthesia?
- ☐ ☐ (Women) are you pregnant? Due date: _____
- ☐ ☐ Have you taken cortisone (steroids)in the last six months?
- ☐ ☐ Do you have any allergies to medication, foods, or things in the environment? If yes, please list allergies and reactions: _____
- ☐ ☐ Are you allergic to latex (rubber) products? List reactions: _____
- ☐ ☐ Are you taking any medications, vitamins, or herbal supplements?
- ☐ ☐ Do you have an active fungal infection? If, so, where? _____

PLEASE LIST ALL MEDICATIONS AND ALLERGIES

⬇ ANESTHESIA PROVIDER USE ONLY ⬇

ANESTHESIA NOTES

SURGERY-A DATE: _____

NPO STATUS: _____

+ - Medications taken today

_____

_____

_____

_____

☐ Patient Screened for OSA, PONV Risk and Excessive Alcohol and Recreational Drug Use
☐ Current Smoker
☐ Smoked on DOS
☐ Did Not Smoke on DOS

ASA CLASS: 1 2 3 4

Anesthesia Plan: MAC with Local Anesthesia/IV Sedation

Reviewed by: _____

☐ CRNA ☐ MD

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