

PRE- ANESTHETIC EVALUATION (Patient to complete sections 1, 2, 3 and 4.)

Date _____ Name _____

Proposed Procedure _____

B/P _____ Pulse _____ Resp _____ PO2 _____

Temp _____ Ht _____ Wt in kg _____ Wt in lbs _____

ALLERGIES:

1. HISTORY OF DISEASE: MARK YES OR NO AND CIRCLE CONDITION IF MORE THAN ONE LISTED.

	YES	NO		YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendencies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
History of Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy/Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Irregular or Fast Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Organ or Tissue Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty opening mouth or moving neck	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew tobacco or use snuff?	<input type="checkbox"/>	<input type="checkbox"/>	type	Amount	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	type	Amount	
Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	type	Amount	
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	type	Amount	
Other diseases, conditions, or problems we should know about?					

2. DRUG HISTORY: HAVE YOU TAKEN ANY OF THESE DRUGS IN THE LAST SIX MONTHS?

	YES	NO		YES	NO
Heart Medications	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers/Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Medication	<input type="checkbox"/>	<input type="checkbox"/>	Narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Medicines	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Medications	<input type="checkbox"/>	<input type="checkbox"/>	Growth Hormone	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis Medications	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or Anticoagulants (blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>

3. LIST YOUR CURRENT MEDICATIONS AND DOSAGE AND CONTINUE ON BACK...

4. PERSONAL HISTORY:

When did you last eat or drink? _____ What and how much? _____

What surgeries have you had? _____

Do you have a personal or family history of problems with anesthesia? Yes No

Do you have: Upper or Lower dentures; loose broken missing or capped or bonded teeth?

Are you wearing contact lenses? Yes No

RN Signature _____ Patient Signature _____

(PHYSICIAN NOTES ONLY BELOW THIS LINE)

PRE-ANESTHESIA:

History & Physical Reviewed Pertinent Lab, Xray, etc. Reviewed ASA Class (circle) I II III IV V

Anesthesia Plan: Sedation/Analgesia General Spinal Regional Local Other _____

Risks, Options, and Plan for anesthesia discussed with and explained to the patient and/or family

Patient assessed immediately prior to initiating the planned anesthesia and is an appropriate candidate

Remarks _____

Post-Anesthesia:

Awake and Alert Vital Signs Stable Complications: None Yes

PHYSICIAN SIGNATURE