PATIENT _____ SURGEON _____

PROCEDURE DATE ____ /____ / ____ PROCEDURE _____

What is the best number to contact you in case of a question? _____

DATE OF BIRTH ____ /____ / ____ SEX ____M ____F HEIGHT _____ inches WEIGHT _____ pounds

Primary Care Physician: _____

PLEASE ANSWER THE QUESTIONS AND MARK ONLY THE CONDITIONS THAT YOU HAVE EVER HAD

Have you ever had a HEART or BLOOD VESSEL condition or HIGH BLOOD PRESSURE? NO YES UNSURE

- ❑ Heart attack Date /____/____
- ❑ Congestive heart failure (fluid on the lungs/swollen legs or feet)
- ❑ Heart murmur
- ❑ Congenital heart disease (born with a heart problem)
- ❑ Abnormal electrocardiogram (EKG)
- ❑ Heart or bypass surgery
- ❑ Heart transplant
- ❑ Pacemaker or defibrillator
- ❑ Angina or Chest Pain
- ❑ High blood pressure
- ❑ Heart valve problems
- ❑ High cholesterol
- ❑ Irregular or rapid heartbeat
- ❑ Angioplasty, stent, or balloon procedure
- ❑ Aneurysm or blood vessel problem
- ❑ Other heart condition or procedure (DESCRIBE) _____

Have you ever had any specialized HEART TESTS? NO YES UNSURE

- ❑ Echocardiogram (heart ultrasound) Where_____ When_____
- ❑ Heart catheterization (angiogram) Where_____ When_____
- ❑ Stress Test Where _____ When_____
- ❑ Heart CT scan Where _____ When_____

Check the box that matches your ACTIVITY LEVEL.

- ❑ Standard light home activities; Walk around the house; Walk 1-2 blocks on level ground
- ❑ Climb a flight of stairs, walk up a hill; Walk on level ground; Run a short distance; Moderate activities (golf, dancing, mountain walk)
- ❑ Strenuous sports (swimming, tennis, bicycle); Heavy professional work
- ❑ Unable to perform any of the above. Explain _____

Have you ever had BREATHING problems or a LUNG condition? NO YES UNSURE

- ❑ Asthma Number of ER visits within last year _____
- ❑ Chronic cough ❑ with phlegm
- ❑ Recent cold, respiratory infection, fever, or chills (last 2 weeks)
- ❑ Sleep apnea or very loud snoring
- ❑ Use oxygen at home
- ❑ Use steroids
- ❑ Lung surgery
- ❑ Lung transplant
- ❑ Emphysema or COPD
- ❑ Short of breath when lying down flat
- ❑ Recent pneumonia (last 2 months)
- ❑ Home ventilator (CPAP or BPAP)
- ❑ Blood clot in lungs (pulmonary embolism)
- ❑ Use inhaler
- ❑ Tuberculosis
- ❑ Cystic fibrosis
- ❑ Other lung or breathing condition (DESCRIBE) _____

Have you had a LIVER, KIDNEY, or PROSTATE condition? NO YES UNSURE

- ❑ Hepatitis or jaundice (except as newborn)
- ❑ Cirrhosis of the liver
- ❑ Liver surgery
- ❑ Liver transplant
- ❑ Enlarged prostate
- ❑ Prostate cancer
- ❑ Kidney failure
- ❑ Blood hemodialysis
- ❑ Peritoneal dialysis
- ❑ Kidney surgery
- ❑ Kidney transplant
- ❑ Urinary tract infection
- ❑ Oher (DESCRIBE) _____

Have you had a DIABETES, PANCREAS, THYROID, or PARATHYROID condition? NO YES UNSURE

- ❑ Diabetes
- ❑ Insulin treatment
- ❑ Pancreas transplant
- ❑ Hypoglycemia
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Other (DESCRIBE) _____

Have you had an EAR, EYE, ORAL, DIGESTIVE, or WEIGHT problem? NO YES UNSURE

- ❑ Glaucoma
- ❑ Speech/language problem
- ❑ Chipped, loose or fragile teeth
- ❑ TMJ (jaw joint problem)
- ❑ Acid reflux, heartburn, GERD, or hiatal hernia
- ❑ Severe weight loss or undernourished
- ❑ Sight deficit
- ❑ Hearing deficit
- ❑ Dentures/partials
- ❑ Take diet medications within the last 2 weeks
- ❑ Anorexia/bulimia
- ❑ Obesity (overweight)
- ❑ Other (DESCRIBE) _____

Do you have any SKIN problems? NO YES UNSURE

❑ Lesions ❑ Burns ❑ Bruising ❑ Open Wounds ❑ Drainage

Have you had a BRAIN, NERVE, MUSCLE, OR MENTAL HEALTH condition? NO YES UNSURE

- ❑ Stroke or TIA (ministroke)
- ❑ Numbness or weakness (hands/feet/face)
- ❑ Carpal tunnel
- ❑ Multiple sclerosis
- ❑ Headaches (severe)
- ❑ Depression (severe)
- ❑ Seizures, convulsions, or epilepsy. Last event _____
- ❑ Paralysis/Polio
- ❑ Myasthenia gravis
- ❑ Muscular dystrophy
- ❑ Schizophrenia
- ❑ Anxiety (severe)
- ❑ Bipolar
- ❑ ADD / ADHD
- ❑ Other (DESCRIBE) _____

Have you had ARTHRITIS, SPINE, or JOINT problems? NO YES UNSURE

- ❑ Osteoarthritis (degenerative arthritis)
- ❑ Rheumatoid arthritis
- ❑ Spine problems ____ Neck ____ Upper back ____ Lower back
- ❑ Other (DESCRIBE) _____

Have you had a BLOOD disorder? NO YES UNSURE

- ❑ Anemia
- ❑ Leukemia
- ❑ Abnormal bleeding or bruising
- ❑ Polycythemia
- ❑ Sickle cell disease
- ❑ Sickle cell trait
- ❑ Thrombosis (blood clot)
- ❑ Bone marrow transplant
- ❑ Other (DESCRIBE) _____

Have you had CANCER, LEUKEMIA, LYMPHOMA, or other MALIGNANCY? NO YES UNSURE

- ❑ Type _____
- ❑ Chemotherapy
- ❑ Radiation
- ❑ Bone marrow transplant
- ❑ Adriamycin
- ❑ Bleomycin

Have you had any DIFFICULTIES or COMPLICATIONS with ANESTHESIA or SURGERY? NO YES UNSURE

- ❑ Difficult intubation (breathing tube insertion)
- ❑ Awareness (remembering being in surgery)
- ❑ Malignant hyperthermia (very high fever with anesthesia)
- ❑ Difficulty waking up
- ❑ Severe nausea or vomiting
- ❑ Other (DESCRIBE) _____

Are you HIV positive? Do you have AIDS or any other INFECTIOUS DISEASE? NO YES UNSURE

- ❑ HIV
- ❑ AIDS
- ❑ Staph where _____ when _____
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ MRSA where _____ when _____
- ❑ Other (DESCRIBE) _____

CHILDREN: Is patient 2 years old or less? NO YES UNSURE

- ❑ Premature How Much? _____
- ❑ Birth weight ____ lbs ____ oz
- ❑ Breathing problems at birth
- ❑ History of tracheostomy
- ❑ Other newborn problems (DESCRIBE) _____

WOMEN: Is there any chance that you are now PREGNANT? NO YES UNSURE

- ❑ Birth control pills
- ❑ Tubes tied
- ❑ Date of last menstrual period ___ /___ /___
- ❑ Birth Control Implant where _____
- ❑ IUD
- ❑ Hysterectomy
- ❑ Depo Provera last injection date _____

WOMEN: Are you currently breast-feeding? NO YES UNSURE

SOCIAL HISTORY: Profession: _____

Have you SMOKED cigarettes? Do you drink ALCOHOL or use DRUGS? NO YES UNSURE

- ❑ Cigarettes _____ packs per day _____ years
- ❑ Quit smoking year _____
- ❑ Other tobacco usage _____
- ❑ Alcohol _____ drinks per week
- ❑ Marijuana
- ❑ Cocaine
- ❑ Methamphetamine

Other (DESCRIBE) _____

FAMILY HISTORY:

Does your FAMILY have a history of any of the following? NO YES UNSURE

- ❑ Family history of severe reactions to anesthesia
- ❑ Family history of high cholesterol
- ❑ Family history of heart disease before age 60 years
- ❑ Malignant hyperthermia (very high fever with anesthesia
- ❑ Family history of muscle weakness disease
- ❑ Family history of myasthenia gravis
- ❑ Family history of muscular dystrophy
- ❑ Family history of high blood pressure
- ❑ Other (DESCRIBE) _____

Have you taken BLOOD THINNERS within the past 2 weeks? NO YES UNSURE

❑ Plavix ❑ Coumadin ❑ Aspirin ❑ Lovenox ❑ Heparin Other _____

Have you taken ANTICONVULSANT/SEIZURE MEDICATION within the past 6 months? NO YES UNSURE

Have you taken DIGOXIN within the past 2 weeks? NO YES UNSURE

Have you taken DIURETICS within the past 2 weeks? NO YES UNSURE

Have you been given IV CONTRAST (DYE) within the past 2 weeks? NO YES UNSURE

Have you taken any of the following within the past 6 months? NO YES UNSURE

❑ Azathioprine (Imuran) ❑ Cyclosporine (Neoral, Sandimmune) ❑ Methotrexate (Rheumatrex, Trexail)

❑ Mycophenolate (Cellcept, Myfortic) ❑ Sirolimus (Rapamune) ❑ Tacrolimus (Prograf)

Have you taken STEROIDS within the past 6 months? NO YES UNSURE

Have you taken THEOPHYLLINE within the past 2 weeks? NO YES UNSURE

Have you ever had a blood transfusion? NO YES UNSURE

Do you refuse to have a blood transfusion? NO YES UNSURE

LIST PAST SURGERIES WITH YEAR

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List ALLERGIES & REACTIONS to medications, tapes, foods, or to latex rubber

_____ _____ _____ _____

_____ _____ _____ _____

List all PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS along with HERBAL PREPARATIONS

Drug	Amount	How often	Reason for Taking	Drug	Amount	How often	Reason for Taking

Do you have any OTHER CONDITIONS or CONCERNS about ANESTHESIA OR SURGERY? NO YES UNSURE

_____

Completed by: _____ **Date:** _____ **Time:** _____

THIS PAGE TO BE COMPLETED BY ANESTHESIA

Pre-Anesthesia Evaluation

Signature: _____ **Date:** _____ **Time** _____

ANESTHESIOLOGY EVALUATION:

T_____ **P**_____ **R**_____ **BP**_____/_____ **SaO_2**_____**%** **NPO since**_____ **T & S X Match**

Pertinent Labs:

Physical Exam:

Airway Class 1 2 3 4 Neck ROM: ❑ Full ❑ Limited

Mandibular subluxation: ❑ Normal ❑ Decreased

Teeth: ❑ Intact ❑ Caps ❑ Loose ❑ Missing ❑ Chipped

Dentures/Partials ❑ Upper ❑ Lower

Cardiac Rhythm: ❑ Reg. ❑ Irreg. Murmur ____/__6__

Lungs: ❑ Clear ❑ Diminished ❑ Wheezes ❑ Rales ❑ Rhonchi

Gross Neuro Deficits: ❑ None

Mental Status: ❑ Awake ❑ Drowsy ❑ Confused ❑ Unresponsive

DAY OF PROCEDURE ANESTHESIA REVIEW & PLAN **ASA CLASS: 1 2 3 4 5 E**

❑ Pre-anesthesia assessment reviewed

❑ Risks, benefits, & alternatives of planned anesthesia and possible blood products discussed. Patient or parent/guardian agree to proceed.

❑ DNR / AND suspension for perioperative anesthesia discussed with patient/family.

ANESTHETIC PLAN: GA-OET GA-NET GA-LMA GA-MASK DLT AWAKE RSI MAC POPBLK TIVA

SAB EPI CAUDAL AXBLK ISCBLK FEMBLK IVBLK ANKLEBLK AL CL RHC 2DTEE

ANESTHESIOLOGIST: _____ **TRANS #** _____ **DATE** ____/____/____ **TIME** _____