PRE-ANESTHESIA EVALUATION

Name: _____

Please indicate by a check (✓) your answer to each question.

Date: _____

Your Age:	Height:	Weight:
Planned Operation:		

Have you had or do you still have:	Yes	No	Anesthesiology Dept. Only
Do you smoke, Vapor, Nicotine Patch, etc?			
A cold within past 2 weeks			
Bronchitis, a cough within past 2 weeks ☐			
Pneumonia within past 2 weeks ☐			
Frequent sinus problems			
Emphysema ☐			
Asthma ☐			
Shortness of breath ☐			
Sleep Apnea ☐			
Tuberculosis			
Any other lung trouble			
High blood pressure ☐			
Low blood pressure ❑			
Stroke ❑			
High Cholesterol ❑			
Heart murmur ☐			
Chest pain, angina ☐			
Heart attack(s) ☐			
Palpitations, irregular or fast heartbeat ☐			
Rheumatic fever			
Gastric bypass ☐			
Anemia ☐			
Sickle cell illness			
Excessive bruising, excessive bleeding ☐			
Jaundice, hepatitis, liver trouble			
Back pain or injury			
Slipped disc. Sciatica			
Arthritis, other joint pain			
Convulsions, epilepsy or seizures ☐			
Fainting, blackout spells			
DVT ☐			
Polio, paralysis, meningitis			
Neuro muscular disease ☐			
Thyroid trouble			
Diabetes ☐			
Low blood sugar			
Kidney trouble			
Eye problems			
Infectious diseases (hepatitis, AIDS, MRSA) ☐			
Any Other illnesses not listed above:			
Are you allergic to any local anesthetic drugs ☐			
Have you or anyone in your family had an unusual reaction to anesthesia ☐			
Frequent Heartburn/Reflux/Hiatal Hernia ☐			
Post-op Nausea or Vomiting ☐			
List of surgeries you had:			
Have you had or object to blood transfusion			
Do you have any removable dental work, plates, bridges, capped teeth, ☐			
TMJ (Tempro Mandibular Joint) ☐			
Do you drink alcohol			
Are you or could you be pregnant now			
Any serious illness during pregnancy			
Have you had dark or chocolate colored urine			
Elevated temperature after exercise			
Family history of unexplained death after exercise			

List Medications Currently Taking

Medication Allergies:

❑ **None** ❑**Eggs** ❑ **Latex**

Patient/Guardian Signature:

Pre-Op Vital Signs:

BP P R OXY % T

EKG

CXR

PREG TEST

ABG LFS

PT PTT PLAT.

Hgb Electrolytes: Cl Na

Hct K CO^2

BS BUN Creat.

Remarks: NPO From:

Mallampti score_____

ANESTHESIA PLAN

ASA PS I II III IV V E

General _____Regional _____ Mac_____

Type

Risk/Benefit/Option/Discussed with patient or guardian:

Pre-op Ordered:

Signature Date/ Time:

Pregnancy Test Yes No N/A Public Files Rev 04/2019