

# 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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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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CRNA             MD