

PREOPERATIVE ANESTHESIA ASSESSMENT

SECTION A - MEDICAL HISTORY (TO BE COMPLETED BY PATIENT)

1. Each item below is preceded by a box "□" and a circle "○". Please indicate all of the following that you **have had** by darkening the box "■", and all that you think you **may have had** by darkening the circle "●".

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Missed immunizations | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> A relative with anesthetic problems |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Frequent heartburn | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Loose, chipped or missing teeth |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hospitalized overnight | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anemia | <input type="checkbox"/> Dental caps, bridges or dentures |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Internal bleeding | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Language barrier |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Chronic back pain | <input type="checkbox"/> Positive HIV test |
| <input type="checkbox"/> Unable to lay flat | <input type="checkbox"/> Recent cold or flu | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Seizure | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Objection to a blood transfusion |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Positive PPD test | <input type="checkbox"/> Stroke | <input type="checkbox"/> Recurrent dislocations | <input type="checkbox"/> Serious injury |
| <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Latex or tape allergy |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weakness | <input type="checkbox"/> Share home with smokers | <input type="checkbox"/> Use of herbal treatments |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Other illness not listed |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Snoring | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Recreational drug use | |
| <input type="checkbox"/> Regular exercise routine | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Fainting | <input type="checkbox"/> General anesthesia | |
| <input type="checkbox"/> Serious disability | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Dementia | <input type="checkbox"/> Spinal anesthesia | |
| <input type="checkbox"/> Premature birth | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Problems with anesthesia | |

SECTION B - OTHER INFORMATION (TO BE COMPLETED BY PATIENT)

2. Planned surgery			3. Date of surgery		4. Prior surgeries			
5. Medications you are currently taking					6. Allergies to medicines			
7. Age	8. Height	9. Weight	10. Sex <input type="checkbox"/> M <input type="checkbox"/> F	11. Home phone		12. Work phone	13a. Date	13b. Time
14a. Printed name					14b. Signature			

SECTION C - ANESTHESIA PROVIDER ONLY

15. Comments													
16. BP		17. Pulse		18. Respiration		19. Temperature		20. SaO2		21. Pain scale		22. NPO past	
23. Airway Dentition:				Mallampati score:									
24. Cardiovascular						25. Pulmonary							
26. HCT		27. HCG		28. EKG				29. CXR					
30. Special instructions								31. Medications ordered					
32. ASA <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV				33. Anesthesia plan <input type="checkbox"/> MAC <input type="checkbox"/> Spinal <input type="checkbox"/> General <input type="checkbox"/> Other:									

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

COUNSELING STATEMENT: The risks and benefits of anesthetic options were discussed. The patient or legal guardian understands and consents to the anesthetic plan. NPO status was explained. All questions were answered.

Signature	
Date	Time