ANESTHESIA PRE-OP ASSESSMENT

cover this area with sticker

Procedure:_____

Surgeon: _____

DRUG ALLERGIES:_____

Anesthesia History:

N Y History of high fever **from anesthesia** in you or a family member? (Malignant Hyperthermia)

N Y History of nausea/vomiting after anesthesia?

N Y History of difficult intubation?

N Y Any other problems with anesthesia?

Do you smoke/vape? N Y Amount:_____ Do you use marijuana products? N Y How Often:_____

Do you drink alcohol? N Y How Often:_____

List **ANY** previous surgeries/procedures:_____

_____

Circle Y (yes) if you have any of the following medical conditions.

CARDIOVASCULAR Cardiologist: _____

Y Heart Attack-Date
Y Recent chest pain
Y High blood pressure
Y Murmur or valve problem
Y Congestive heart failure
Y Irregular heartbeat
Y Stress test-Date
Y Heart catheterization to look for blockage
Y Ever had heart stents, angioplasty, or heart bypass surgery
Y Pacemaker or Defibrillator
Y High Cholesterol METS>4 ❑

RESPIRATORY

Y Asthma
Y COPD
Y Home oxygen
Y Pneumonia or bronchitis in past 6 wks

ENDOCRINE

Y Diabetes - on insulin/ oral med/ injections (circle) BS= _____
Y Hyperthyroid or Hypothyroid

SLEEP

Y Sleep apnea (if yes, skip 3 questions below) Do you use CPAP? N Y
Y Do you snore loudly?
Y Are you tired or sleepy during the daytime?
Y Has anyone observed you stop breathing during sleep?

PEDIATRICS (answer if <12 years old)

Y Born full term (>37 weeks)
Y NICU Stay
Y Ever hospitalized since birth?

NEUROLOGIC

Y Stroke-Date
Y Seizure-last one
Y Neuropathy (numbness/tingling in hands or feet)
Y Anxiety or Depression
Y Bipolar or PTSD
Y Dementia
Y Muscular Dystrophy or myopathy

GASTROINTESTINAL

Y Acid reflux or heartburn
Y Hepatitis or cirrhosis
Y Gastroparesis

HEMATOLOGIC

Y History of anemia; sickle cell N Y
Y Hx of bleeding disorder
Y Blood transfusion-Date & reason:_____
Y Do you take a blood thinner or Aspirin
Y Ever had a blood clot/ DVT/ PE

MUSCULOSKELETAL

Y Arthritis
Y Chronic pain-where?
Y Fibromyalgia

OTHER

Y Kidney disease
Y History of cancer, type-_____
Y History of radiation or chemotherapy
Y TMJ syndrome
Y Treated with steroids in past 6 mos. For?_____

TEETH (circle any that apply)

Chipped Loose Missing Front caps Dentures Partials

OTHER MEDICAL PROBLEMS?

OFFICIAL USE ONLY BELOW

Home Medications:

Comments/Labs:

Weight: kg

NPO since: ❑Midnight

Sleep Apnea Screen:

___Snore ___BMI
___Tired ___Age
___Obstruct ___Neck
___Pressure ___Gender

❑ **HIGH RISK sleep apnea pt.**

___Took water with meds this AM
___Tylenol__Gabapentin__Celebrex
___ Robaxin __Other_____

Airway: Mall. 1 2 3 4 ASA: 1 2 3

Anesthetic Plan: **GA PNB Local MAC**

❑ Discussed risks, benefits, and alternatives. Patient and/or legal guardian expresses understanding and accepts proposed anesthetic.
❑Anesthesia Consent Signed.

CRNA :

Anesthesiologist :

Diagnosis: