cover this
with sticker

ANESTHESIA PRE-OP ASSESSMENT

Procedure:_____
Age:_____
DRUG ALLERGIES:_____

Do you smoke? N Y Amount?_____, use Alcohol? N Y How often?_____

LIST PREV. SURGERIES: _____
_____

Anesthesia History:
N Y History of high fever **after anesthesia** in you or a family member?(Malignant Hyperthermia)
N Y History of nausea/vomiting after anesthesia?
N Y Any other known problems with anesthesia?

Patient Medical History: (Y=Yes - circle any that apply)

CARDIOVASCULAR
Y Heart Attack-Date
Y Recent chest pain
Y High blood pressure
Y History of heart valve problem
Y History of 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

RESPIRATORY
Y Asthma
Y COPD
Y Pneumonia or bronchitis in past 6 wks
Y Exposure to TB

ENDOCRINE
Y Diabetes-on insulin/oral med./both (circle)
Y Thyroid disease

SLEEP
Y Have you been diagnosed with sleep apnea? (If yes, skip next 3 "sleep" questions) **Do you use CPAP? Y N**
Y Are you frequently sleepy during the day (more than normal) despite adequate sleep?
Y Have you been told people notice you obstructing your breathing while sleeping?
Y Have you been told you snore loud enough to be heard in another room?

NEUROLOGIC
Y Stroke-Date
Y Seizure-last one
Y Neuropathy (numbness/tingling in hands or feet)
Y High anxiety or panic disorder
Y Depression or Bipolar disease

GASTROINTESTINAL
Y Acid reflux requiring daily meds
Y History of hepatitis
Y Peptic ulcer

HEMATOLOGIC
Y History of anemia; **sickle cell disease Y N**
Y Blood transfusion-Date & reason:_____
Y Do you take a blood thinner
Y Ever had a blood clot

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 MED PROBLEMS?

OFFICIAL USE ONLY BELOW

Pt. Meds

Comments/Labs:

Wt: lb.

NPO since:

Sleep Apnea Screen:
___**S**nore ___**B**MI
___**T**ired ___**A**ge
___**O**bstruct ___**N**eck
___**P**ressure ___**G**ender
❑ HIGH RISK sleep apnea pt.

___took meds with water this AM
__celebrex, ___tylenol, ___ other

Airway: **ASA:**

Anesthetic Plan:

___Discussed risks, benefits, and alternatives; patient and or legal guardian express understanding and accept proposed anesthetic

CRNA/RN:

Anesthesiologist: