The Center for Specialized Surgery

Pre-Anesthesia Evaluation

Ht. _____Wt._____ BMI_____

Cell Phone_____ Is it okay to leave a message on voicemail? Yes ☐ No ☐

Primary Care Physician:_____ Phone #:_____Fax#:_____

Medical History

Pt./Family Hx. of anesth. related problem: ☐ No ☐ Yes Explain:_____

Previous Sx:_____

_____

Current Medications: See Medication Reconciliation Form

Allergies: _____

Latex Allergy: ☐ No ☐ **Yes-Fill out Latex Questionnaire**

Cardiovascular

NONE **AICD *Must be seen by an Anesthesiologist. Bring Card.**

☐ MI ☐ Chest Pain ☐ HTN ☐ Palpitations/irregular heartbeat ☐ A-Fib ☐ Mitral Valve Prolapse

☐ CHF ☐ Pacemaker- When was it last checked?_____

EKG? ☐ No ☐ Yes When?_____ Where?_____

Stress Test? ☐ No ☐ Yes When?_____Where?_____

Cardiologist:_____ Phone #:_____ Fax#:_____

Last Visit:_____ Were you sent for Clearance? ☐ Yes ☐ No

☐ **Exercise tolerance** Do you exercise on a regular basis? ☐ Yes ☐ No

Can you walk up a flight of stairs without SOB or Chest Pain? ☐ Yes ☐ No

If on blood thinners, did your cardiologist say you could be off for 5 days? ☐ Yes ☐ No ☐ Haven't asked

Neuromuscular

☐ NONE

☐ Stroke/TIA When?_____ Weakness? ☐ Yes Where?_____ ☐ Polio ☐ Memory Problems

☐ Seizures ☐ Migraines ☐ Dizziness ☐ Neuropathy ☐ Fibromyalgia

☐ Muscle/Joint problems? _____ Able to tilt head back? ☐ Yes ☐ No

☐ Back/Neck Pain? Where?_____

Respiratory

☐ NONE

☐ **TMJ/Jaw Surgery, Hx of difficult intubation *Must be seen by Anesthesiologist**

☐ COPD ☐ Asthma ☐ Bronchitis/Chronic Cough ☐ TB ☐ Pneumonia ☐ SOB ☐ with min exertion?

How far can you walk before getting SOB?_____

☐ Cold within last 2 weeks? ☐ Smoke?PPD_____ Years_____ ☐ Quit? When?_____

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☐ Sleep Apnea-Do you wear a CPAP Machine? ☐ Yes ☐ No

☐ O2 at home? When?_____ L/min_____

GI ☐ NONE

☐ Hepatitis B or C ☐ Liver Disease ☐ Hiatal Hernia ☐ Ulcers

☐ GERD –Controlled by meds? ☐ Yes ☐ No-have breakthrough ☐ Not on anything

GU ☐ NONE

☐ **Dialysis *Must be seen by Anesthesiologist**

☐ Renal Failure ☐ BPH ☐ Menopause Last menses?_____ ☐ Incontinence

Hematalogic/Endocrine ☐ NONE

☐ Anemia ☐ HIV ☐ Sickle Cell ☐ Bleeding DO ☐ Hyper/Hypo Thyroid ☐ Diabetes ☐ Oral

☐ Insulin ☐ Diet Controlled ☐ Do you check your blood sugar every day? ☐ Yes ☐ No

What do your sugars run on average?_____

Psychosocial

Do you feel safe in your home? ☐ Yes ☐ No If no, why not?_____

Have you ever wanted to harm yourself? ☐ Yes ☐ No

Do you want to harm yourself at this time? ☐ Yes ☐ No

☐ Disability- specify_____ ☐ Psych. Disorder_____

☐ Cultural/Ethnic/Religious issues/concerns_____

☐ Advance Directives ☐ Living Will ☐ Durable Power of Attorney ☐ None

Other

Alcohol ☐ No ☐ Yes Amount_____ ☐ Drug Use_____

Do you have a pain management doctor? ☐ Yes ☐ No

Do you have your Rx for after surgery? ☐ Yes ☐ No ☐ Dentures/Caps/Crowns

To the best of my knowledge this information is correct.

Patient Signature_____ Date/Time:_____

HX Taken By:_____ Date/Time_____

Comments:_____ ☐ **Patient must be brought in**