

Preanesthesia Evaluation

**INSTRUCTIONS TO PATIENT:** Please indicate by a check (✓) your answer to each question. These answers will greatly help your anesthesia provider to give you his/her best care during your operation. If you do not understand any question (or your answer is uncertain), simply place a question mark (?) in the YES or NO column.

Do You Have or Have You Been Treated By A Physician For Any of The Following? (Please Check Yes or No)

| YES                       | NO                       | YES                      | NO                          |                          |                          |
|---------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| High Blood Pressure       | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, Seizures          | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pains, Angina       | <input type="checkbox"/> | <input type="checkbox"/> | Aneurysm                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attacks             | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing       | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Bypass              | <input type="checkbox"/> | <input type="checkbox"/> | Down's Syndrome             | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Stents              | <input type="checkbox"/> | <input type="checkbox"/> | Premature Birth             | <input type="checkbox"/> | <input type="checkbox"/> |
| Automatic Defibrillator   | <input type="checkbox"/> | <input type="checkbox"/> | Spinal Problems             | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker                 | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Disorder             | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive Heart Failure  | <input type="checkbox"/> | <input type="checkbox"/> | Anemia                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmurs             | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia / Trait  | <input type="checkbox"/> | <input type="checkbox"/> |
| Prolapsed Mitral Valve    | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia, Blood Probs     | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heartbeat       | <input type="checkbox"/> | <input type="checkbox"/> | Previous Blood Transfusion  | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                    | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive                | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema COPD            | <input type="checkbox"/> | <input type="checkbox"/> | AIDS                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Home Oxygen               | <input type="checkbox"/> | <input type="checkbox"/> | Steroid Treatment Past Year | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis, Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | Chipped or Cracked Teeth    | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Breathing      | <input type="checkbox"/> | <input type="checkbox"/> | Dentures                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Apnea               | <input type="checkbox"/> | <input type="checkbox"/> | Implantable Devices         | <input type="checkbox"/> | <input type="checkbox"/> |
| Hiatal Hernia             | <input type="checkbox"/> | <input type="checkbox"/> | Claustrophobia              | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Ulcer             | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Acid Reflux               | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Cirrhosis of Liver        | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Hepatitis A B or C        | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Kidney Failure            | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| On Dialysis?              | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Thyroid Problems          | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Diabetes                  | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| IF YES,                   |                          |                          |                             |                          |                          |
| Diet Controlled           | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Oral Medication           | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Insulin                   | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |
| Stroke                    | <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                          |

Use of Tobacco?  
☐ Yes ☐ No  
☐ Previously

Type: \_\_\_\_\_  
How Much? \_\_\_\_\_

Use of Alcohol?  
☐ Yes ☐ No

Type: \_\_\_\_\_  
HowMuch? \_\_\_\_\_

Use of Addicting Drugs?  
☐ Yes ☐ No

Height \_\_\_\_\_  
Weight \_\_\_\_\_ lbs / kg

Other Health Problems Not Mentioned Above  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGY TO MEDS (Type of Reaction)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ No Allergies

Allergy to Eggs, Latex, Peanuts, or Soy?  
☐ Yes ☐ No

MEDICATION AND DOSAGES USED AT HOME  
(Prescription/Non-Prescription), Medication List Attached ☐

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PREVIOUS SURGERY  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any problems with you or your family during/after anesthesia? ☐ Yes ☐ No

FEMALE: Date of Last Menstrual Cycle \_\_\_\_\_

Are You Pregnant? ☐ Yes ☐ No

PATIENT / AUTHORIZED SIGNATURE

FOR ANESTHESIA PROVIDER ONLY

Alternatives and risks of anesthesia to include death, disfigurement, or disability were discussed. ☐ Yes ☐ No

Patient Accepts? ☐ Yes ☐ No

Questions Answered? ☐ Yes ☐ No

NPO: \_\_\_\_\_ Comments: \_\_\_\_\_

Blood: ☐ Yes ☐ No Hgb / Hct \_\_\_\_\_

CXR: ☐ Yes ☐ No K+ \_\_\_\_\_

ECG: ☐ Yes ☐ No UPT \_\_\_\_\_

ASA Status: 1 2 3 4

Anesthesia Plan: ☐ General ☐ Regional ☐ MAC

☐ Patient accepts anesthesia care team

☐ Patient is cleared for surgery/ procedure at ASC

☐ Discussed non-opiate and opiate reduction alternatives

Airway Exam: \_\_\_\_\_

Premedications

NTP \_\_\_\_\_ inches

Bicitra \_\_\_\_\_ ml



|                                                                                                                        |           |  |        |  |                                                                                                             |  |                  |  |       |  |    |
|------------------------------------------------------------------------------------------------------------------------|-----------|--|--------|--|-------------------------------------------------------------------------------------------------------------|--|------------------|--|-------|--|----|
| DATE                                                                                                                   | DIAGNOSIS |  |        |  |                                                                                                             |  |                  |  |       |  |    |
| TEETH POST-OP UNCHANGED <input type="checkbox"/>                                                                       | PROCEDURE |  |        |  |                                                                                                             |  | BEGAN            |  | ENDED |  |    |
| ASA CLASS                                                                                                              | HbG       |  | Kg / # |  | PREMEDICATION                                                                                               |  | DOSE             |  | TIME  |  | BY |
| 1 2 3 4                                                                                                                |           |  |        |  | PROPOFOL                                                                                                    |  |                  |  |       |  |    |
| DRUG ALLERGIES                                                                                                         |           |  |        |  | FENTANYL / DILAUDID                                                                                         |  |                  |  |       |  |    |
| REMARKS                                                                                                                |           |  |        |  |                                                                                                             |  |                  |  |       |  |    |
| <input type="checkbox"/> MACHINE CHECKED <input type="checkbox"/> PT IDENTIFIED <input type="checkbox"/> SITE VERIFIED |           |  |        |  |                                                                                                             |  |                  |  |       |  |    |
| <input type="checkbox"/> EXTREMITIES PRESSURE POINTS, EYES PROTECTED                                                   |           |  |        |  | MIDAZOLAM / VALIUM                                                                                          |  |                  |  |       |  |    |
| COMMENTS                                                                                                               |           |  |        |  | <input type="checkbox"/> ANTIBIOTICS INITIATED                                                              |  |                  |  |       |  |    |
|                                                                                                                        |           |  |        |  | <input type="checkbox"/> ACTIVE WARMING MEASURES USED (BAIR HUGGER)                                         |  |                  |  |       |  |    |
| <input type="checkbox"/> SUCTIONED AND EXTUBATED                                                                       |           |  |        |  | SURGEONS                                                                                                    |  |                  |  |       |  |    |
|                                                                                                                        |           |  |        |  | ANESTHESIA                                                                                                  |  | BEGAN            |  | ENDED |  |    |
|                                                                                                                        |           |  |        |  | <input type="checkbox"/> GENERAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> MAC             |  |                  |  |       |  |    |
|                                                                                                                        |           |  |        |  | Anesthesia Timeout                                                                                          |  | Surgical Timeout |  |       |  |    |
|                                                                                                                        |           |  |        |  | IV R _____ 9 L _____ 9                                                                                      |  |                  |  |       |  |    |
|                                                                                                                        |           |  |        |  | INTUBATION: <input type="checkbox"/> CRICOID+ <input type="checkbox"/> ETCD2+ <input type="checkbox"/> BBS+ |  |                  |  |       |  |    |
|                                                                                                                        |           |  |        |  | ORAL _____ NASAL _____ LMA _____                                                                            |  |                  |  |       |  |    |
|                                                                                                                        |           |  |        |  | SIZE _____ BLADE _____                                                                                      |  |                  |  |       |  |    |
|                                                                                                                        |           |  |        |  | AIRWAY: O-P _____ N-P _____ HME _____                                                                       |  |                  |  |       |  |    |

ASC 04 (2S)