Outpatient Surgery Magazine

Pre-Anesthesia Evaluation Form

Courtesy of Anesthesia Professionals Inc.

October 2014

PRE-ANESTHESIA EVALUATION

PATIENT

CHART#

DATE

PHYSICAL

Age:_____ Height:_____ Weight: _____

MEDICAL HISTORY QUESTIONNAIRE

Yes No

- ☐ ☐ Do you have a heart condition?
- ☐ ☐ Have you had a heart attack? When?_____
- ☐ ☐ Have you had chest pain? How often?_____
- ☐ ☐ Do you have a pacemaker or implanted defibrillator?
- ☐ ☐ Do you have high blood pressure?
- ☐ ☐ Have you ever had a stroke? When? _____
- ☐ ☐ Do you have asthma, bronchitis, or any other breathing problem?
- ☐ ☐ Do you experience shortness of breath?
- ☐ ☐ Do you (or did you) smoke?
  Packs/day:____ Number of years:_____ Date you quit: _____
- ☐ ☐ Have you recently had a cold or the flu?
- ☐ ☐ Do you have diabetes?
- ☐ ☐ Do you have a thyroid condition?
- ☐ ☐ Do you have or have had kidney disease?
- ☐ ☐ Have you had hepatitis, liver disease, or jaundice?
- ☐ ☐ Do you have any stomach problems, reflux disease, hiatal hernia, heart burn, ulcers, or GERD?
- ☐ ☐ Do you have bleeding problems or take aspirin, Coumadin or Plavix?
- ☐ ☐ Do you have numbness, weakness, or paralysis of your extremities?
- ☐ ☐ Can you lie still on your back for the procedure?
- ☐ ☐ Have you ever had a seizure?
  How often?_____ Last seizure: _____
- ☐ ☐ Do you consume alcohol? Drinks per week: _____
- ☐ ☐ Do you take or have you taken recreational drugs?
- ☐ ☐ Have you or any blood relative had difficulties with anesthesia?
- ☐ ☐ Have you had any nausea/vomiting with anesthesia?
- ☐ ☐ (Women) are you pregnant? Due date: _____
- ☐ ☐ (Men) Have you ever taken the drug Flomax for prostate problems?
- ☐ ☐ Do you have any allergies to medication, foods, or things in the environment? If Yes, please list allergies and reactions on Page 2.
- ☐ ☐ Are you allergic to latex (rubber) products? List reactions on Page 2.
- ☐ ☐ Are you taking any medications, vitamins, or herbal supplements?

PLEASE LIST ALL MEDICATIONS AND ALLERGIES ON PAGE 2 OF THIS FORM

⬇! ANESTHESIA PROVIDER USE ONLY ⬇!

ANESTHESIA NOTES

SURGERY-A DATE: _____

SURGERY TYPE: _____

NPO STATUS: _____

\+ – Medications taken today

ASA CLASS: 1 2 3 4 E

Anesthesia Plan: MAC with Local Anesthesia/IV Sedation

Reviewed by: _____

☐ CRNA ☐ MD

ANESTHESIA NOTES

SURGERY-B DATE: _____

SURGERY TYPE: _____

NPO STATUS: _____

\+ – Medications taken today

ASA CLASS: 1 2 3 4 E

Anesthesia Plan: MAC with Local Anesthesia/IV Sedation

Reviewed by: _____

☐ CRNA ☐ MD

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PRE-ANESTHESIA EVALUATION AND MEDICATION ADMINISTRATION RECORD

MEDICATIONS AND SUPPLEMENTS

PATIENT

CHART#

SURGERY-A DATE: _____

SURGERY-B DATE: _____

A	B	Medication	Dose	Frequency	A	B	Medication	Dose	Frequency
☐	☐				☐	☐			
☐	☐				☐	☐			
☐	☐				☐	☐			
☐	☐				☐	☐			
☐	☐				☐	☐			
☐	☐				☐	☐			
☐	☐				☐	☐			
☐	☐				☐	☐			

☐ = Patient took this medication / vitamin / herbal supplement today

Patient's Pharmacy Address Phone

ALLERGIES AND REACTIONS

Allergy/Reaction

Allergy/Reaction

ADVANCE DIRECTIVE

Yes ☐ No ☐ Have you ever signed a Living Will, Do Not Resuscitate Order, or any other type of "advance directive" legal document instructing your doctor on what kind of care you would like to have if you become unable to make medical decisions on your own (e.g., if you are in a coma)?

ACKNOWLEDGEMENT

The information on this form is accurate to the best of my knowledge. I have been informed (verbally and in writing) about my rights/responsibilities, advance directive and physician financial interest.

Date Patient or Guardian Name (Please Print) Patient or Guardian Signature

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