Patient Name: _____

DOB: _____

Surgery Date: _____

MED REC #: _____

PRESURGICAL AND ANESTHESIA EVALUATION CHECKLIST

Please answer the following questions. These responses will help us provide the best possible care for you.

CARDIAC	NEURO
YES NO Have you experienced anginal chest pain?	YES NO Do you have back or neck pain?
YES NO Do you have a heart condition?	YES NO Do you have numbness, weakness, or paralysis of your extremities?
YES NO Have you ever had a heart attack?	YES NO Do you have any muscle or nerve disease?
YES NO Do you have a heart murmur?	YES NO Have you had convulsions, seizures or epilepsy?
YES NO Do you have hypertension (high blood pressure)?	YES NO Have you experienced headaches, dizziness,light- headedness or fainting?
YES NO Do you have a pacemaker or defibrillator?	

RESPIRATORY	SOCIAL
YES NO Do you experience shortness of breath?	YES NO Do you drink alcohol? # per week:
YES NO Do you have asthma, bronchitis, or any other breathing problem?	YES NO Do you take or have you taken recreational/ street drugs?
YES NO Do you have sleep apnea? CPAP?	YES NO Do you use herbal medications, home remedies or over the counter medications ?
YES NO Do you (or did you) smoke? # of packs per day _____ .# of years _____.	
YES NO When did you quit smoking? _____	

GI/ GU	ALLERGIES
YES NO Have you had hepatitis, liver disease or jaundice?	Medication allergies:_____
YES NO Do you have ulcers, reflux, or other stomach disorders?	Please describe reactions:_____
YES NO Do you have a hiatal hernia?	
YES NO Do you have or have you had kidney problems or have you had dialysis?	Food: ___Kiwi ___ Guava ___ Soy Bean ___ Eggs
YES NO Do you have Crohn's Disease or Irritable Bowel Disease?	OTHER ALLERGIES:

NAME:_____

DOB:_____

ALLERGIES:_____

_____

MED REC#:_____

PRESURGICAL AND ANESTHESIA EVALUATION PATIENT

OTHER	SURGERIES/ HOSPITALIZATIONS/ ADDITIONAL INFO
YES NO Do you have a thyroid condition?	YES NO
YES NO Do you have or have you had an infectious disease?	PLEASE DESCRIBE:
YES NO Do you have arthritis ?	
YES NO Do you have any bleeding problems?	
YES NO Do you take blood thinners (Coumadin, Aspirin, Plavix, Ticlid etc?) Last Dosage ? _____	**LIVING WILL/ POWER OF ATTORNEY**
YES NO Do you have or have you had cancer?	YES NO Do you have a living will?
YES NO Have you or any blood relatives had difficulties with anesthesia ?	YES NO Do you have Power of Attorney?
YES NO Do you have loose, chipped, false teeth or bridgework?	YES NO Would you like information on living will?
YES NO Do you wear contact lenses/ glasses?	**Patient's Signature:** _____ Date:_____
YES NO Do you wear a hearing aid?	**TO BE COMPLETED BY STAFF: VITAL SIGNS**
YES NO Do you have any skin problems?	Blood pressure:_____ Pulse: Height:_____ Weight:_____
FEMALES ONLY: YES NO Are you pregnant? YES NO Are you nursing? Last menstrual date:_____	Respirations:_____ Temperature:_____ Pulse Oximetry:_____
	PRESURGICAL & ANESTHESIA EVALUATION REVIEWED BY: RN:_____DATE:_____ CRNA:_____DATE:_____

MEDICATION LIST

PATIENT NAME _____ **DATE**_____

Please complete the following form prior to your appointment and bring this form with you. Be sure to include ALL MEDICINES INCLUDING VITAMINS, HERBS, AND OVER THE COUNTER DRUGS (i.e. aspirin, Vitamin E, Viagra) and/or any recreational drugs, (i.e. Marijuana, Methamphetamine etc.) as well as your prescription drugs and the amount and frequency you take of them. Certain drugs that you take may affect drugs that we use in anesthesia so please be honest! If you are unable to complete this form please bring all of your medications to your appointment and someone will assist you to fill out this form.

Name of Medication	Dosage (i.e. 25 mg)	How often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		