Pre-Anesthesia Assessment

Name: _____ Birthdate: _____ Age: _____ Gender: _____ Ht: _____ Wt: _____

Address: _____ City,State,Zip: _____

Home # : _____ Cell # : _____ Email: _____

Emergency Contact (Name and Phone #): _____

Surgeon: _____ Surgery Date: _____ Type: _____

LIST ALL ALLERGIES / REACTIONS	ALL MEDICATIONS/VITAMINS/HERBS	PRIOR SURGERIES

Do you have, or have you ever had:	Yes	No	If yes, please explain
Anesthesia related problems such as nausea, difficulty awakening, a relative with a serious anesthetic problem, or history of difficult intubation?			
Personal or family history of Malignant Hyperthermia, fever after exercise, or dark-colored urine?			
High blood pressure, heart problems such as chest pain, murmur, arrhythmia, heart attack, congestive heart failure, or abnormal EKG?			
Lung disease, shortness of breath (with or without exertion), asthma, chronic cough, sleep apnea, or narcolepsy?			
Diabetes, abnormal thyroid function, easy bruising, sickle cell disease?			
Liver Disease: hepatitis, pancreatitis, anemia?			
Kidney Disease?			
Heartburn, gastric reflux, hiatal hernia, acid or food coming up into your throat, difficulty swallowing, or delayed stomach emptying?			
Back pain, neck pain, muscle disease, headaches, seizures, numbness in an extremity, or surgery on your spine?			
Chipped or loose teeth, crowns, veneers, dental implants, bridgework?			
A reaction to local anesthetics given for dental or other procedures?			
Glaucoma, problems with vision, contact lenses?			
Allergic reaction to eggs or soy products?			
Are you taking any blood thinning (anti-coagulant) medications, aspirin, anti-inflammatory medications, or herbal supplements?			
Are you under the care of a psychiatrist or therapist?			
Do you want to be tested for pregnancy?			Last period:
Any medical conditions that have not been mentioned above?			
Any alcohol or recreational drug use? Indicate type/amount/frequency.			
Do you smoke? Please indicate amount, and if current or former.			

I have read this entire form, or have had it read to me. I have answered these questions accurately. I will provide a responsible adult to transport me home and remain with me for a minimum of 24 hours after surgery.

Patient Signature: _____ Date: _____ Time: _____

Transport Name: _____ Cell # : _____

(this person must be available at all times, by phone, while you are in surgery)

~Anesthesia Provider's Use Only~

Baseline Vitals- BP: P: R: T:	
Room Air O2 Sat:	Rhythm on Monitor:
Airway:	Heart/Lungs:
Anesthetic Plan: Signature:	

[Label]