

Pre-Anesthesia Evaluation

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Telephone Numbers: Please provide DAY TIME PHONE NUMBER for anesthesiologist to contact you prior to surgery:

Daytime Phone: _____ Cell Number: _____

List All Current Medications (both prescription and over the counter): _____

List all prior surgeries: _____

Allergies: List Drug Allergies: _____

Please Circle YES or NO, If YES Circle Disorder

- YES NO Have you ever had problems with anesthesia?
- YES NO Do you have any allergies to soy or egg products?
- YES NO Are you allergic to latex?
- YES NO Are you aware of any member of your family having had malignant hyperthermia (i.e. a high fever associated with anesthesia)?
- YES NO Do you have any heart problems: High Blood Pressure, Mital Valve Prolapse, Heart disease, Heart Attack, Angina?
- YES NO Do you have any gastrointestinal problems including: Hepatitis, Heartburn, Hiatal Hernia, Ulcers, Gallstones?
- YES NO Do you have any skin problems including: Herpes, Rashes, Eczema?
- YES NO Do you have any blood disorders including: Sickle Cell, Anemia, Mono, Clotting Disorder, Deep Vein Thrombosis?
- YES NO Do you have Diabetes?
- YES NO Do you have a Thyroid Disorder?
- YES NO Have you ever had a Seizure, Stroke, or Aneurysm?
- YES NO Do you have any Neurological disorders?
- YES NO Do you have any breathing problems including: Asthma, COPD, or Emphysema, Sleep Apnea?
- YES NO After climbing a flight of stairs, are you short of breath?
- YES NO Do you have any kidney problems including: Renal Failure, Urinary Tract Infections, Kidney Stones?
- YES NO Do you have any limitations on the use of any joints, especially the neck and jaw?
- YES NO Do you have Arthritis?
- YES NO Do you have any fractures?
- YES NO Do you have Cancer?
- YES NO Do you have any infectious diseases or are you a carrier of any infectious diseases?
- YES NO Have you ever had a HIV test? If yes, was it positive or negative? _____

If YES to any of the above questions please explain: _____

Have you had or do you have any other medical conditions not covered above? _____

- YES NO Do you smoke? Packs per day? _____ How many years? _____
If quit, how long ago? _____
- YES NO Do you use alcohol? If yes, how much? _____
- YES NO Do you wear contact lens?
- YES NO Do you have dentures, partials, etc.? _____
- YES NO Do you have an emotional condition?
If yes, please explain: _____

Female Patients Only:

- YES NO Could you be pregnant? Date of last period: _____
- YES NO Have you had a Hysterectomy?
- YES NO Have you had a Tubal Ligation?

I agree to have nothing to eat or drink eight (8) hours prior to my surgery this includes gum, candy, mints, etc... unless instructed to do so by anesthesiologist or physician.

Patient Signature

Date