Patient Name in full:			Time In:
DOB	Male❒	Female❒	Height _____ Weight _____ BMI _____
DOS	Primary Care Provider:		Phone #:

Allergies/Sensitivities including Foods (Bannana, Kiwi, Nuts, Avocado) **Reactions:**

Latex Allergy: Yes❒ No ❒ If yes what is the reaction?

Anesthesia History: None ❒ General ❒ Epidural ❒ Spinal ❒ IV Sedation ❒ OTHER_____

	YES	NO
Any previous anesthesia complications?		
Any post op nausea❒ vomiting❒		
High fevers associated with anesthesia?		
Are you anxious about surgery?		
CARDIOVASCULAR		
Irregular heart beat❒ palpitations❒		
Chest Pain❒ Angina❒* Frequency:		
Skipped beat❒ fluttering❒		
Heart murmur❒ Rheumatic Fever❒		
Blood Pressure Low❒ High❒ Controlled❒ Uncontrolled❒		
Phlebitis Last Episode_____		
Blood clots Last episode_____		
Anticoagulation therapy*(blood thinner)		
Surgery on heart❒ arteries❒* when_____		
Do you have a pace maker? When_____		
Do you have heart stents? When_____		
BLOOD		
Previous blood transfusion? When_____		
Aspirin❒ NSAID (anti-inflammatory)❒		
Abnormal bleeding❒ bruising❒		
Anemia❒ Leukemia❒ Mononucleosis❒		
Ever exposed to any risk factors that might lead to HIV/AIDS ?		
NERVOUS SYSTEM		
Frequent blackouts❒ dizzy spells❒		
Brain Tumor Diagnosed when_____		
Stroke when_____		
weakness❒ numbness❒ paralysis❒		
Epilepsy❒ seizure❒ Last episode_____		
Any trouble with back❒ neck❒		
KIDNEY AND BLADDER		
Kidney infections❒ stones❒		
Blood in urine❒		
Kidney failure❒ dialysis❒ Stage_____		
Incontinence: Urinary❒ Bowel❒		

AIRWAY/LUNGS	YES	NO
Problems opening mouth wide or TMJ		
Trouble breathing through nose		
Sleep Apnea❒ Cpap machine❒		
Are you on Oxygen? LPM_____		
Witnessed apnea spells		
Shortness of breath❒ wheezing❒		
Cough❒ Cold❒ at present time		
Frequent bronchitis❒ pneumonia❒		
Asthma controlled❒ uncontrolled❒		
COPD controlled❒ uncontrolled❒		
Emphysema controlled❒ uncontrolled❒		
History of TB or any of the following symptoms: unexplained weightloss❒ night sweats❒ coughing up blood❒ persistent, productive cough❒		
TB positive skin test❒ TB exposure❒		
Tobacco Use #of years_____ # pks per day_____ Stop date_____		
Dip❒ Chew❒		
Vaccine: Pneumonia❒ Flu❒ Year:		
Abnormal chest x-ray Date_____		
GASTROINTESTINAL		
Frequent nausea❒ vomiting❒ gallbladder problems❒ intestinal problems❒ hiatal hernia ❒ heartburn❒ reflux❒ motion sickness❒		
LIVER		
Hepatitis❒ yellow jaundice❒ cirrhosis❒		
History of alcohol #drinks a day_____		
History of drugs frequency_____		
GYN		
Last Menstral period_____		
Pregnant❒ or possible❒?		
DENTAL		
Check all that apply: Dentures❒ Caps❒ Lower❒ Upper❒ Bridges❒ Crowns❒		

Nurse Completing Signature:_____
Date: **Time:**

AnesthesiaSignature:_____
Date: **Time:**

Pre Admit Assessment Form	**PRE ADMIT PATIENT STICKER HERE**	**PATIENT STICKER HERE**

Rev 5/12, 10/12, 10/14

DIABETES/ENDOCRINE	YES	NO
Treated by Insulin❒ Pills❒ Diet❒		
Controlled❒ uncontrolled❒		
Hypoglycemia❒ Thyroid Problems❒		
EYES		
Check all that apply: Blindness❒ Lasik❒ Contact Lens❒ Glasses❒ Implants❒ Glaucoma❒ Cataracts❒		
History of MRSA❒ other infection❒ If yes: Where_____When_____		

OTHER	YES	NO
History of Arthritis❒ Lupus❒		
History of Fractures Where_____		
Hard of Hearing❒ hearing aid❒		
Total joint replacement Where_____		
Are you taking any investigational drugs?		
Artificial limb Where_____ Limb Restriction Limb_____		
Cancer Type_____ When_____		
Other chronic illness(see nurse notes)		
Body piercings (all types)		

Please list Previous Surgeries including the date: _____

History obtained from: **Relationship to Patient:**

Nurse's Notes:

Pre- Admit VS: B/P_____P_____R_____T_____Sp02_____ **ASA Classification ____(As Per Pre Admit Assessment Aquired)**

Nurse's Signature: **Date:** **Time:**

History reviewed byPreOp Nurse_____ Reviewed by Sedation Nurse_____

Pre-Op VS: B/P_____ P_____ R_____ T_____ O2Sat_____

FOR ANESTHESIA USE ONLY

PRE-ANESTHESIA EVALUATION

❒ Patient history including previous surgery,anesthesia history,medications & PreAdmit Assessment Form reviewed.

Cardiovascular ❒WNL or _____

Respiratory ❒WNL or _____ **M-I** ❒

Airway ❒WNL or _____ **M-II** ❒

Lung Sounds ❒CTAB or _____ **M-III** ❒

	NORMAL	ABNORMAL	NA
Lab	❒	❒	❒
EKG	❒	❒	❒
Xray	❒	❒	❒

ASA Classification 1❒ 2❒ 3❒ 4❒ 5❒ E❒

Proposed Anesthetic General❒ Spinal❒ MAC❒ Regional❒

❒Discussed anesthesia plan&risk with patient & family

❒ Agreed on plan

Anesthesiologist/CRNA Signature:_____

Date: **Time:**

POST-ANESTHESIA EVALUATION

❒VS B/P_____P_____R_____T____O2Sat____

❒Patient awake & alert ❒Airway_____

❒Cardiac and Pulmonary Status WNL

Pain Rating ____ / 10

Nausea / Vomiting ❒Yes ❒No

Fluid Intake ❒PO ❒IV

❒No anesthetic complications in PACU

Comments:

Other Notes:

Anesthesiologist/CRNA Signature:_____

Date: **Time:**

Notes:

Pre-op History/Assessment Anesthesia Pre/Post Assessment	Pre Admit Sticker Here if Applicable	Patient Sticker Here Rev 5/12, 10/12, 10/14