PATIENT NAME IN FULL:____________________

DOB:______________ Male ☐ Female ☐ Height:________ Weight:________ BMI:________

DOS:______________ Primary care provider:____________________ Phone #:____________________

Allergies/sensitivities including foods (banana, kiwi, nuts, avocado) — Reactions:____________________

Latex allergy: Yes ☐ No ☐ If yes, what is the reaction? ____________________

Anesthesia history: None ☐ Epidural ☐ General ☐ 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 ☐ or High ☐ & Controlled ☐ or Uncontrolled ☐		
Phlebitis — Last episode____________		
Blood clots — Last episode____________		
Anticoagulation therapy (blood thinner)		
Surgery on heart ☐ Arteries ☐ When____________		
Do you have a pacemaker? 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 ☐		

	YES	NO
AIRWAY/LUNGS		
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:	Anesthesia signature:____________________ Date: Time:

PRE-ADMIT ASSESSMENT FORM	PRE-ADMIT PATIENT STICKER HERE	PATIENT STICKER HERE

	YES	NO
DIABETES/ENDOCRINE		
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___________		

	YES	NO
OTHER		
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 dates: ______________________________

____

____

____

History obtained from:______________________________ Relationship to patient:______________________________

FOR ADMINISTRATION USE ONLY

Nurse's notes:

Pre-admit VS: B/P_______P_______R_______T_______Sp02_______ ASA Classification _______(as per pre-admit assessment acquired)

Nurse's signature:______________________________ Date:__________________ Time:________________

History reviewed by pre-op 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 & pre-admit assessment form reviewed.

Cardiovascular ☐ WNL or__________________________
Respiratory ☐ WNL or__________________________
Airway ☐ WNL or__________________________
Lung Sounds ☐ CTAB or__________________________

M-I ☐
M-II ☐
M-III ☐

	NORMAL	ABNORMAL	NA
Lab	☐	☐	☐
EKG	☐	☐	☐
X-ray	☐	☐	☐

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:

Other notes:

PRE-OP HISTORY/ASSESSMENT ANESTHESIA PRE/POST-ASSESSMENT	PRE-ADMIT STICKER HERE IF APPLICABLE	PATIENT STICKER HERE