OneCore Health

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_____02Sat_____

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_____02Sat_____
☐ 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