PINE CREEK MEDICAL CENTER

AFFIX PATIENT LABEL HERE

PRE-ANESTHETIC EVALUATION

PATIENT QUESTIONNAIRE: ***What procedure is being done today?*** _____

(To be completed by patient, family member or responsible party. Please review and mark any problems you may have now, or have had in the past.)

☐ High Blood Pressure	☐ Anemia	☐ Stroke	☐ Diabetes	☐ Kidney Problems
☐ Heart Disease	☐ Blood Transfusion	☐ Fainting/Blackout	☐ Thyroid Problems	☐ Loose/Chip Teeth
☐ Heart Attack	☐ Chest Pain	☐ Seizure	☐ Steroid Use	☐ False Teeth/Caps
☐ Breathing Problems	☐ Leg Pain/Cramps	☐ Mental Problems	☐ Irregular Heart Beat	☐ Neck Pain/Stiffness
☐ Angina	☐ Asthma	☐ Migraine Headache	☐ Chemotherapy	☐ Hoarseness
☐ Cancer	☐ Bronchitis	☐ Nerve Injury	☐ Radiotherapy	☐ Difficulty Opening Mouth
☐ Unable to Exercise	☐ Short of Breath	☐ Paralysis	☐ Liver Problems	
☐ Rheumatic Fever	☐ Pneumonia	☐ Back Injury	☐ Hepatitis	
☐ Chronic Cough	☐ Sinus	☐ Neck Injury	☐ Jaundice	
☐ Bleeding Tendency	☐ Recent Cold/Flu	☐ Herniated Disk	☐ Hiatal Hernia	
☐ Hemophilia	☐ Emphysema	☐ Weakness	☐ Frequent Heart Burn	
☐ Easy Bruising	☐ Tuberculosis	☐ Arthritis	☐ Ulcers	

Tobacco: Yes/No Amount: _____ packs per day for_____ years

Alcohol: Yes/No Amount: _____

Street/Recreational Drugs: Yes/No Types: _____

Could You Be Pregnant? Yes/No

Start Date of Last Menstrual Period _____ /_____ /_____

Ever Tested For AIDS or HIV Yes/No

Results: _____

Drug Allergies: _____

_____

_____

Medications: _____

_____

_____

List of any medical problems not listed above: _____

_____

_____

List of Previous Surgery/Surgeries: _____

_____

Problems with Anesthesia: Yes/No _____

Family History of Problems:

☐ High Temperature	☐ Hoarseness or Sore Throat
☐ Allergic Reaction	☐ Muscle Soreness
☐ Delayed Awakening	☐ Jaundice
☐ Prolonged Weakness	☐ Headache
☐ Nausea and Vomiting	☐ Excessive Bleeding
	☐ Difficulty with Breathing Tube

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge, I am aware that my answers could affect my health care, or that of the patient of whom I am responsible.

Date_____ /_____ /_____ Signature of Patient, Parent, or Responsible Party: _____Relationship_____

NURSING ASSESSMENT: ***(To be completed by nurse)***

Age: _____ Height: _____ Weight: _____ Blood Pressure: _____ / _____ P:_____ R:_____ T:_____ C/F 02 Sat RA: _____ %

Questionnaire review with patient/family; patient's history and heath status as noted above. Additional notes by nurse: _____

_____

_____ ☐ Additional comments on separate sheet.

Signature of Nurse:_____ Date: _____ /_____ /_____Time: _____ : _____a.m. /p.m.

ANESTHESIA PRE-OPERATIVE EVALUATION: ***Must be completed by Anesthesia Provider. Immediately prior to surgery.***

Questionnaire review with patient/family; patient's history and heath status as noted above. Additional comments including pertinent findings from history, physical exam, and diagnosis tests: _____

_____

Physical Examination: C-V system: _____ Lungs: _____

PRE-OPERATIVE TEST RESULTS: Labs:_____ ECG:_____ CXray: _____

Impression: ASA Classification: 1 2 3 4 5 E

NPO Status:_____

Airway:_____

Problem List:_____

_____

_____

Plan:_____

Premed: _____

Monitors: _____ Routine:_____

I have discussed the anesthetic plan, alternatives, benefits, risks, and complications with the patient (or responsible party). Questions have been invited and answered. Patient or the guardian understands and consents. ☐ Additional comments on separate sheet.

TIME:_____:_____a.m./p.m.

CRNA: _____ ANESTHESIOLOGIST: _____ DATE: _____/_____/_____