

Pre-Anesthesia Assessment

The amount of medication given to you during your procedure is adjusted according to your height and weight.

Current: Height? _____ Weight? _____ Age? _____

Have you had surgery before? Yes No If so, when and what kind of surgery?

Have you or any members of your family had problems, INCLUDING FEVER, with prior anesthetics?(blood rel)
 Yes No if yes, explain: _____

Have you had any drug reactions or drug allergies? Yes No : If so, please list

Circle if you have any of the following allergies: Latex Iodine / Betadine Seafood / Shellfish Morphine / Demerol
 Sulfur / Eggs IVP dye

Do you have or have you had any of the following?	Yes	No	If Yes, give additional information
A. Thyroid or goiter problems			
B. Diabetes or hypoglycemia			
C. Epilepsy or seizures			
D. High blood pressure or stroke			
E. Heart disease or mitral valve prolapse			
F. Chest pain or angina (pacemaker/defib.)			
G. Lung disease or emphysema			
H. Chronic cough, asthma, or shortness of breath			
I. Hepatitis, cirrhosis, or jaundice			
J. Kidney disease			
K. Ulcers or hiatal hernia			
L. Anemia or sickle cell disease			
M. Recent weight loss			

Are you now or have you ever been in a drug recovery program? Yes No
 Do you drink more than 2 alcoholic beverages daily? Yes No If so, how many?
 Do you smoke? Yes No If yes, _____ Packs per day for _____ years.

PLACE PATIENT ID LABEL HERE

	Yes	No	Additional Information
Have you had broken facial bones?			
Have you had back, jaw, or nose surgery?			
Do you use eye drops or wear contact lens?			
Do you have loose teeth, caps, crowns, or dentures?			
Have you had an abnormal chest film or EKG?			
Do you have back trouble?			
Are you pregnant?			
If not, when was your last period?			
Have you had blood transfusion?			
Do you take blood-thinning medications?			

Have you ever been diagnosed or told you are positive for HIV (virus that causes AIDS)? Yes No

Do you have any other illness or medical condition not mentioned above (e.g. cancer, neurological, etc?) Yes No

Do you presently take any medications? If so, please list the medication you take and the amount and frequency:

Do you take vitamins, herbal medications, or herbal drinks? If so, please list and the amount and frequency

Patient's or guardian's signature

Date

Preadmission Screening Nurse _____ Date _____

BRAD Received Yes or No (circle) DPOA Yes or No (circle)

Anesthesia Care Provider's (ACP) ASA : See Anesthesia Record

Respiratory: Bi-laterally clear Yes NO Other

Cardiac: Regular Rate & Rhythm, No Significant Murmur Yes NO Other

Anesthesia Care Provider's Signature: _____ **Date:** _____

I have reviewed the anesthesia-related and procedural risks on this patient for this procedure

Supervising physician signature if indicated _____ Date _____ Time _____