**ANESTHESIA PRE-OP ASSESSMENT**

Procedure: ____________________________________________________________

Age: ____________________________

DRUG ALLERGIES: _______________________________________________________

Do you smoke? N Y Amount? ___________ use Alcohol? N Y How often? ______________

**LIST PREV. SURGERIES:** ______________________________________________

- **Patient Medical History:** (Y=Yes - circle any that apply)

  **CARDIOVASCULAR**
  - Y Heart Attack-Date
  - Y Recent chest pain
  - Y High blood pressure
  - Y History of heart valve problem
  - Y History of congestive heart failure
  - Y Irregular heartbeat
  - Y Stress test-Date
  - Y Heart catheterization to look for blockage
  - Y Ever had heart stents, angioplasty, or heart bypass surgery
  - Y Pacemaker or Defibrillator

  **RESPIRATORY**
  - Y Asthma
  - Y COPD
  - Y Pneumonia or bronchitis in past 6 wks
  - Y Exposure to TB

  **ENDOCRINE**
  - Y Diabetes-on insulin/oral med./both (circle)
  - Y Thyroid disease

  **SLEEP**
  - Y Have you been diagnosed with sleep apnea? (If yes, skip next 3 “sleep” questions) Do you use CPAP? Y N
  - Y Are you frequently sleepy during the day (more than normal) despite adequate sleep?
  - Y Have you been told people notice you obstructing your breathing while sleeping?
  - Y Have you been told you snore loud enough to be heard in another room?

  **NEUROLOGIC**
  - Y Stroke-Date
  - Y Seizure-last one
  - Y Neuropathy (numbness/tingling in hands or feet)
  - Y High anxiety or panic disorder
  - Y Depression or Bipolar disease

  **GASTROINTESTINAL**
  - Y Acid reflux requiring daily meds
  - Y History of hepatitis
  - Y Peptic ulcer

  **HEMATOLOGIC**
  - Y History of anemia; sickle cell disease Y N
  - Y Blood transfusion-Date & reason: ____________________________
  - Y Do you take a blood thinner
  - Y Ever had a blood clot

  **MUSCULOSKELETAL**
  - Y Arthritis
  - Y Chronic pain-where?
  - Y Fibromyalgia

  **OTHER**
  - Y Kidney disease
  - Y History of cancer? Type- ____________________________
  - Y History of radiation or chemotherapy
  - Y TMJ syndrome
  - Y Treated with steroids in past 6 mos? For? ____________________________

  **TEETH** (circle any that apply)
  - Chipped
  - Loose
  - Missing
  - Front caps
  - Dentures
  - Partial

**OFFICIAL USE ONLY BELOW**

Pt. Meds | Comments/Labs: | Sleep Apnea Screen:
---|---|---
| | | __Snore ___BMI
| | | __Tired ___Age
| | | __Obstruct ___Neck
| | | __Pressure ___Gender
| | | ___took meds with water this AM
| | | _celebrex, _tylenol, _other

Airway: ASA: ____________

Anesthetic Plan:

- Discussed risks, benefits, and alternatives; patient and or legal guardian express understanding and accept proposed anesthetic

CRNA/RN: ____________

Anesthesiologist: ____________