

PATIENT \_\_\_\_\_ SURGEON \_\_\_\_\_  
 PROCEDURE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ PROCEDURE \_\_\_\_\_  
 What is the best number to contact you in case of a question? \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX \_\_\_M\_\_\_F HEIGHT \_\_\_\_\_ inches WEIGHT \_\_\_\_\_ pounds  
 Primary Care Physician: \_\_\_\_\_

**PLEASE ANSWER THE QUESTIONS AND MARK *ONLY* THE CONDITIONS THAT YOU HAVE EVER HAD**

**Have you ever had a HEART or BLOOD VESSEL condition or HIGH BLOOD PRESSURE?** NO YES UNSURE  
 Heart attack Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Angina or chest pain  
 Congestive heart failure (fluid on the lungs/swollen legs or feet)  High blood pressure  
 Heart murmur  Heart valve problem  
 Congenital heart disease (born with a heart problem)  High cholesterol  
 Abnormal electrocardiogram (EKG)  Irregular or rapid heartbeat  
 Heart or bypass surgery  Angioplasty, stent, or balloon procedure  
 Heart transplant  Aneurysm or blood vessel problem  
 Pacemaker or defibrillator  
 Other heart condition or procedure (DESCRIBE) \_\_\_\_\_

**Have you ever had any specialized HEART TESTS?** NO YES UNSURE  
 Echocardiogram (heart ultrasound)  Stress test  
 Heart catheterization (angiogram)  Heart CT scan  
 If so, where was test performed at? \_\_\_\_\_

**Do you become severely SHORT OF BREATH with any of the activities listed below?** NO YES UNSURE  
 Climbing a flight of stairs/ Walking up a hill  Walking a mile  
 Heavy housework (scrubbing floors, lifting/moving furniture)  Running a short distance

**Have you ever had BREATHING problems or a LUNG condition?** NO YES UNSURE  
 Asthma Number of ER visits within past year \_\_\_\_\_  Emphysema or COPD  
 Chronic cough  with phlegm  Short of breath when lying down flat  
 Recent cold, respiratory infection, fever, or chills (last 2 weeks)  Recent pneumonia (last 2 months)  
 Sleep apnea or very loud snoring  Home ventilator (CPAP or BPAP)  
 Use oxygen at home  Blood clot in lungs (pulmonary embolism)  
 Use steroids  Use inhaler  
 Lung surgery  Tuberculosis  
 Lung transplant  Cystic fibrosis  
 Other lung or breathing condition (DESCRIBE) \_\_\_\_\_

**Have you had a LIVER, KIDNEY, or PROSTATE condition?** NO YES UNSURE  
 Hepatitis or jaundice (except as newborn)  Kidney failure  
 Cirrhosis of the liver  Blood hemodialysis  
 Liver surgery  Peritoneal dialysis  
 Liver transplant  Kidney surgery  
 Enlarged prostate  Kidney transplant  
 Prostate cancer  Urinary tract infection  
 Other (DESCRIBE) \_\_\_\_\_

**Have you had DIABETES, PANCREAS, THYROID, or PARATHYROID condition?** NO YES UNSURE  
 Diabetes  Hypoglycemia  
 Insulin treatment  Hyperthyroid  
 Pancreas transplant  Hypothyroid  
 Other (DESCRIBE) \_\_\_\_\_

**Have you had an EAR, EYE, ORAL, DIGESTIVE, or WEIGHT problem?** NO YES UNSURE  
 Glaucoma  Sight deficit  
 Speech/language problem  Hearing deficit  
 Chipped, loose, or fragile teeth  Dentures/partials  
 TMJ (jaw joint problem)  Take diet medications  
 Acid reflux, heartburn, GERD, or hiatal hernia  Anorexia/bulimia  
 Severe weight loss or undernourished  Obesity (overweight)  
 Other (DESCRIBE) \_\_\_\_\_

**Do you have any SKIN problems?** NO YES UNSURE  
 Lesions  Burns  Bruising



<b>Have you had a BRAIN, NERVE, MUSCLE, or MENTAL HEALTH condition?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Stroke or TIA (ministroke) <input type="checkbox"/> Numbness or weakness (hands/feet/face) <input type="checkbox"/> Carpal tunnel <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Headaches (severe) <input type="checkbox"/> Depression (severe) <input type="checkbox"/> Other (DESCRIBE) _____			
<input type="checkbox"/> Seizures, convulsions, or epilepsy <input type="checkbox"/> Paralysis/Polio <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Anxiety (severe) <input type="checkbox"/> Bipolar			
<b>Have you had ARTHRITIS, SPINE, or JOINT problems?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Osteoarthritis (degenerative arthritis) <input type="checkbox"/> TMJ (jaw joint problem) <input type="checkbox"/> Spine problems ___ Neck ___ Upper back ___ Lower back <input type="checkbox"/> Other (DESCRIBE) _____			
<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Sciatica			
<b>Have you had a BLOOD disorder?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Abnormal bleeding or bruising <input type="checkbox"/> Polycythemia <input type="checkbox"/> Other (DESCRIBE) _____			
<input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Sickle cell trait <input type="checkbox"/> Thrombosis (blood clot) <input type="checkbox"/> Bone marrow transplant			
<b>Have you had CANCER, LEUKEMIA, LYMPHOMA, or other MALIGNANCY?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Type _____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Bone marrow transplant			
<input type="checkbox"/> Adriamycin <input type="checkbox"/> Bleomycin			
<b>Have you SMOKED cigarettes? Do you drink ALCOHOL or use DRUGS?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Cigarettes _____ packs per day _____ years <input type="checkbox"/> Other tobacco usage _____ <input type="checkbox"/> Alcohol _____ drinks per week <input type="checkbox"/> Other (DESCRIBE) _____			
<input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine			
<b>Have you had any DIFFICULTIES or COMPLICATIONS with ANESTHESIA or SURGERY?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Difficult intubation (breathing tube insertion) <input type="checkbox"/> Awareness (remembering being in surgery) <input type="checkbox"/> Malignant hyperthermia (very high fever with anesthesia) <input type="checkbox"/> Other (DESCRIBE) _____			
<input type="checkbox"/> Difficulty waking up <input type="checkbox"/> Severe nausea or vomiting			
<b>Are you HIV positive? Do you have AIDS or any other INFECTIOUS DISEASE?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> HIV <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other (DESCRIBE) _____			
<input type="checkbox"/> AIDS <input type="checkbox"/> Hepatitis			
<b>Does your FAMILY have a history of any of the following?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Family history of severe reactions to anesthesia <input type="checkbox"/> Family history of high cholesterol <input type="checkbox"/> Family history of heart disease before age 60 years <input type="checkbox"/> Malignant hyperthermia (very high fever with anesthesia) <input type="checkbox"/> Other (DESCRIBE) _____			
<input type="checkbox"/> Family history of muscle weakness disease <input type="checkbox"/> Family history of myasthenia gravis <input type="checkbox"/> Family history of muscular dystrophy			
<b>CHILDREN: Is patient 2 years old or less?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Premature How much? _____ <input type="checkbox"/> Birth weight ___ lbs ___ oz <input type="checkbox"/> Other newborn problems (DESCRIBE) _____			
<input type="checkbox"/> Breathing problems at birth <input type="checkbox"/> History of tracheostomy			
<b>WOMEN: Is there any chance that you are now PREGNANT?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>
<input type="checkbox"/> Birth control pills <input type="checkbox"/> Tubes tied <input type="checkbox"/> Date of last menstrual period ___/___/___			
<input type="checkbox"/> IUD <input type="checkbox"/> Hysterectomy			
<b>WOMEN: Are you currently breast-feeding?</b>	<b>NO</b>	<b>YES</b>	<b>UNSURE</b>

Have you taken **BLOOD THINNERS** within the past 2 weeks? NO YES UNSURE  
 Plavix  Coumadin  Aspirin  Lovenox  Heparin  Other \_\_\_\_\_

Have you taken **ANTICONVULSANT/SEIZURE MEDICATION** within the past 6 months? NO YES UNSURE

Have you taken **DIGOXIN** within the past 2 weeks? NO YES UNSURE

Have you taken **DIURETICS** within the past 2 weeks? NO YES UNSURE

Have you been given **IV CONTRAST (DYE)** within the past 2 weeks? NO YES UNSURE

Have you taken any of the following within the past 6 months? NO YES UNSURE

- Azathioprine (Imuran)     Cyclosporine (Neoral, Sandimmune)     Methotrexate (Rheumatrex, Trexall)  
 Mycophenolate (Cellcept, Myfortic)     Sirolimus (Rapamune)     Tacrolimus (Prograf)

Have you taken **STEROIDS** within the past 6 months? NO YES UNSURE

Have you taken **THEOPHYLLINE** within the past 2 weeks? NO YES UNSURE

Have you ever had a blood transfusion? NO YES UNSURE

Do you refuse to have a blood transfusion? NO YES UNSURE

Have you had **SURGERY** (please list with year)? NO YES UNSURE


Do you have any **ALLERGIES** to medications, tapes, foods, or to latex rubber? (please list with reactions) NO YES UNSURE


Do you take **OVER-THE-COUNTER MEDICINES** or **HERBAL PREPARATIONS**? (please list) NO YES UNSURE


Do you take **PRESCRIBED MEDICINES** ? (please list with dosages) NO YES UNSURE

Drug	Amount	How often	Reason for Taking	Drug	Amount	How often	Reason for Taking
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Do you have any **OTHER CONDITIONS** or **CONCERNS** about **ANESTHESIA OR SURGERY**? NO YES UNSURE

\_\_\_\_\_

Completed by: \_\_\_\_\_

**Preadmission Testing Center Evaluation**

T\_\_\_\_P\_\_\_\_R\_\_\_\_BP\_\_\_\_/\_\_\_\_ SaO2\_\_\_\_%

Notes:

**Pre-procedure Instructions in PAT:**

NPO\_\_\_\_\_

Meds per protocol

Cardiology consult

Pulmonology consult

PAT Evaluation: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**ANESTHESIOLOGY EVALUATION:**

T\_\_\_\_P\_\_\_\_R\_\_\_\_BP\_\_\_\_/\_\_\_\_ SaO2\_\_\_\_%    NPO since\_\_\_\_\_    T & S    X Match

**Pertinent Labs:**

**Physical Exam:**

Airway Class 1 2 3 4    Neck ROM:  Full  Limited

Mandibular subluxation:  Normal  Decreased

Teeth:  Intact  Caps  Loose  Missing  Chipped

          Dentures/Partials  Upper  Lower

Cardiac Rhythm:  Reg.  Irreg.    Murmur \_\_\_\_/\_\_\_\_6\_\_

Lungs:  Clear  Diminished  Wheezes  Rales  Rhonchi

Gross Neuro Deficits:  None

Mental Status:  Awake  Drowsy  Confused  Unresponsive

**DAY OF PROCEDURE ANESTHESIA REVIEW & PLAN                    ASA CLASS: 1 2 3 4 5 E**

Pre-anesthesia assessment reviewed

Risk, benefits, & alternatives of planned anesthesia discussed. Patient or parent/guardian agree to proceed.

ANESTHETIC PLAN:    GA-OET    GA-NET    GA-LMA    GA-MASK    DLT    AWAKE    RSI                    MAC

                          SAB    EPI    CAUDAL    AXBLK    ISCBLK    FEMBLK    IVBLK    ANKLEBLK                    AL CL RHC 2DTEE

ANESTHESIOLOGIST: \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_    TIME \_\_\_\_\_