NAME DATE

WEIGHT	HEIGHT	OCCUPATION
PHONE		SURGEON
AGE	PHYSICAL ACTIVITY NOW ☐ LITTLE ☐ MODERATE ☐ ACTIVE ☐ VERY ACTIVE	PRIMARY PHYSICIAN/CARDIOLOGIST

PAIN SCALE:

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Medium Severe Very Severe Worst

WHAT OPERATIONS HAVE YOU HAD AND APPROXIMATELY WHEN?

_____

_____

_____

_____

WHAT OPERATION ARE YOU HAVING? _____

_____

WHAT KIND OF ANESTHESIA HAVE YOU HAD?

General (asleep) ☐ YES ☐ NO Local ☐ YES ☐ NO

Epidural, Saddle Block or Spinal ☐ YES ☐ NO

GENERAL INFORMATION:

Do you wear contact lenses? ☐ YES ☐ NO

Do you have any body piercing? ☐ YES ☐ NO

Do you have difficulty opening your mouth or moving your head or neck? ☐ YES ☐ NO

Do you have any prosthesis? (i.e., leg, arm, eye) ☐ YES ☐ NO

Do you have removable dentures, caps loose or chipped teeth? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Do you have acid reflux or Gerd? ☐ YES ☐ NO

IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT AT THIS TIME? ☐ YES ☐ NO

FAMILY HISTORY

Have you or anyone in your family had a tendency to bleed excessively? ☐ YES ☐ NO

Have you or anyone in your family had unusual reactions to anesthesia, such as *(please circle)*

Muscle weakness Unexplained fevers Jaundice

Breathing problems Prolonged recovery from anesthesia

A. YOUR MEDICAL HISTORY

1. Have you had heart surgery or procedures or heart disease such as heart attack, irregular heart beat, etc.? ☐ YES ☐ NO
2. Have you had any chest pain or shortness of breath? ☐ YES ☐ NO
3. Do you sleep with more than 2 pillows under your head? ☐ YES ☐ NO
4. If walking up 2 flights of stairs, would you like to stop before finishing due to fatigue? Describe below. ☐ YES ☐ NO
5. Do you have a history of asthma? ☐ YES ☐ NO
6. Do you have a history of emphysema, tuberculosis or other lung diseases? ☐ YES ☐ NO
7. Do you have a history of kidney disease? ☐ YES ☐ NO
8. Do you have a history of seizures/stroke? ☐ YES ☐ NO
9. Do you have a history of high blood pressure? ☐ YES ☐ NO
10. Do you have a history of diabetes? ☐ YES ☐ NO
11. Do you have a history of hepatitis? ☐ YES ☐ NO
12. Do you have a history of drug dependency? ☐ YES ☐ NO
13. Do you have a history of alcohol dependency? ☐ YES ☐ NO
14. Do you have a history of depression or mental illness? ☐ YES ☐ NO
15. Do you have arthritis or related conditions? ☐ YES ☐ NO
16. Do you have any unusual medical history not addressed above? If so, please describe: _____ ☐ YES ☐ NO

    _____
17. Do you have a history of sleep apnea? ☐ YES ☐ NO
18. Have you been a patient in a skilled nursing facility within the last 6 months? ☐ YES ☐ NO

B. MEDICATIONS:

Please list all medication you are taking: (including herbs, over-the-counter meds, and recreational drugs) List dosages and how often taken. Use back of this form to add further info./remarks. ☐ list provided

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY **MEDICINES**? ☐ YES ☐ NO

ARE YOU ALLERGIC TO ADHESIVE TAPE, IODINE, FOOD PRODUCTS OR LATEX? ☐ YES ☐ NO

IF YES TO ANY OF THE ABOVE, IDENTIFY:

_____

Do you have a history of Anesthesia Awareness ☐ YES ☐ NO

Anesthesia Awareness pamphlet made available to patient. ☐ YES ☐ NO

Your anesthesiologist will talk to you and advise you regarding the type of anesthesia considered medically advisable for you. Modern day anesthesia is generally safe. However, you should understand that, like any other medical procedures, the administration of anesthesia is associated with certain risks. Major complications from anesthesia are rare but they can result in death or major disability. Please sign below when you have completed this form to the best of your knowledge and are satisfied you understand its content.

PATIENT/RESPONSIBLE PARTY (signature) - RELATIONSHIP

ANESTHESIOLOGIST (signature)

MR-7020-033 (12/6/06)

DAMERON HOSPITAL

ANESTHESIA DEPARTMENT
PRE-ANESTHESIA EVALUATION