North Florida Surgery Center

PRE-ANESTHESIA ASSESSMENT

Surgeon/Physician: _____ Date: _____

Drug Allergies:	Height	Procedure?
	Weight	
	BMI	
Latex Allergy? Yes / No	Age	Airway:

Mallampati 1 2 3 4
Heart ☐ RRR
Lungs ☐ Clear Bilaterally

Yes	No	HAVE YOU HAD OR STILL HAVE?
☐	☐	Heart Blood Pressure – Take meds today? Y / N
☐	☐	Heart Murmur / Palpitations / Irregular Heartbeat
☐	☐	Chest Pain / Angina
☐	☐	Heart Attack – Date(s) _____
☐	☐	Angioplasty/Coronary Stents Date(s) _____
☐	☐	Heart Surgery Date(s) _____
☐	☐	Congestive Heart Failure
☐	☐	Shortness of Breath at Rest
☐	☐	Shortness of Breath Walking/Climbing/Stairs
☐	☐	Pacemaker / Defibrillator Last Checked _____
☐	☐	Cold in the Past Two Weeks
☐	☐	Fever in the Past 48 Hours
☐	☐	Smoked Tobacco in Past 10 Yrs? Packs per Y r_____
☐	☐	Asthma / Bronchitis / Chronic Cough
☐	☐	Emphysema / COPD / Tuberculosis / Asbestosis
☐	☐	Pneumonia in Past 6 Months?
☐	☐	Do you snore?
☐	☐	Sleep Apnea CPAP Use regularly? _____
☐	☐	Kidney Problems / Dialysis
☐	☐	Anxiety / Depression / BiPolar / Other _____
☐	☐	Stroke / TIA
☐	☐	Convulsion / Epilepsy / Blackouts
☐	☐	Back Pain / Disc Disease
☐	☐	Back Injury / Paralysis / Neurological Deficits
☐	☐	Arm or Leg Numbness / Muscle Weakness
☐	☐	Cancer – Type _____
☐	☐	Hepatitis / Jaundice / Cirrhosis / Liver Disease
☐	☐	Intestinal Ulcers / Reflux Esophagitis / GERD
☐	☐	Diabetes
☐	☐	Thyroid Disease
☐	☐	Anemia / Blood Transfusion / HIV
☐	☐	Would you refuse a blood transfusion if deemed necessary?
☐	☐	Frequent or Severe Headache - Type _____
☐	☐	Osteoarthritis – Location _____
☐	☐	Rheumatoid Arthritis
☐	☐	Prednisone / Steroid Use – Last Taken _____
☐	☐	Recent Abnormal Weight Loss
☐	☐	Weight Reduction Meds
☐	☐	Alcohol Consumption – Drinks per day _____
☐	☐	Post-Op Nausea / Vomiting in the Past?
☐	☐	You / Family: Other Problem with Anesthesia
☐	☐	You / Family: Bleeding Problem
☐	☐	Is there any chance you could be pregnant?
☐	☐	Chipped, Cracked or Loose Teeth
☐	☐	Crowns / Veneers / Partial / Full Denture
☐	☐	Herbal products in last month?

Previous Surgeries:

Labs/Additional Pre-Anesthesia Evaluation (Including Consults)

MEDICATIONS:

Medication review	**Beta Blocker**
☐ Database	☐ None
☐ MAR	☐ Given at (date/time):
☐ H&P	☐ Not indicated due to:

☐ Patient Evaluated/ History Reviewed
☐ Operative Procedure and Site Verified Risks
☐ Discussed and Questions Answered
☐ HCG Negative / Hysterectomy / Menopause

☐ Consent Obtained
☐ NPO > 8 hours ☐ NPO (other) _____
ASA I II III IV V VI E

ANESTHESIA PLAN Including Potential Anesthesia Problems

MAC/LOCAL
GA Induction IV / Inhal
Maint. IV / Inhal

Postop Analgesia: IV / Oral / Block

Crna Date/time

Surgeon Date/time

X

Signature of person completing form **Date/Time**