

Pre-Anesthesia Form (Revised Dec 2009)

Name: _____		Cell #: _____		Work #: _____	
Age: _____	Height: _____	Weight: _____ lbs. <input type="checkbox"/> Stated <input type="checkbox"/> Actual	Home #: _____		Daytime #: _____

Surgeon: \_\_\_\_\_ Surgery Date: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Cardiovascular**

- |   | <u>Yes</u>               | <u>No</u>                | <u>Comments</u> |
|---|--------------------------|--------------------------|-----------------|
| 1. Have you ever had a heart attack, chest pain, heart murmur<br>Or an irregular heartbeat? | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| 2. Do you have a pacemaker or internal defibrillator?                                       | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| 3. Have you ever had <b>High</b> or <b>Low</b> blood pressure?                              | <input type="checkbox"/> | <input type="checkbox"/> | _____           |

**Hematology**

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| 4. Have you had problems with your blood clotting<br>(i.e. easy bleeding or blood clots)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
|---|--------------------------|--------------------------|-------|

**Respiratory**

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| 5. Have you ever had asthma, bronchitis, emphysema,<br>Pneumonia, <b>TB</b> or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Do you experience shortness of breath with climbing stairs<br>and/or routine activities? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Have you had a recent cold, cough, fever, night sweats, fatigue<br>or weight loss?       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**Neurovascular**

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| 8. Do you have motion sickness or vertigo?                  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 9. Have you ever had a seizure or stroke?                   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 10. Do you have numbness or tingling in your hands or feet? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**GI**

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| 11. Have you had a hiatal hernia, ulcer, acid reflux? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
|---|--------------------------|--------------------------|-------|

**Endocrine**

- |                       |                          |                          |       |
|-----------------------|--------------------------|--------------------------|-------|
| 12. Are you diabetic? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
|-----------------------|--------------------------|--------------------------|-------|

If yes, circle one: **Insulin**   **Insulin Pump**   **PO Medications**   **Diet Control**

**Hepato-Renal**

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| 13. Have you ever had jaundice, hepatitis or cirrhosis of the liver? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 14. Have you ever had any problems with your kidneys?                | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**General**

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| 15. Do you have any major illnesses not listed above?   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 16. Have you or any blood relative ever experienced any<br>Complications related to anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 17. Do you have a previous history of nausea and vomiting<br>after surgery?                     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 18. Do you wear contacts, eye glasses or hearing aides?   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 19. Do you have loose or false teeth or caps/crowns/bridgework?                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

