PREANESTHETIC EVALUATION
PRESURGICAL EVALUATION

PATIENT SYSTEMS REVIEW (☐ Completed by patient or responsible party ☐ Completed by nurse)

Please review and mark any problems you may have now or have had in the past.

☐ high blood pressure	☐ heart disease	☐ heart attack	☐ chest pain	☐ angina
☐ rheumatic fever	☐ bleeding disorder	☐ hemophilia	☐ bleed or bruise easily	☐ sleep apnea
☐ asthma	☐ breathing problems	☐ bronchitis	☐ tuberculosis	☐ emphysema
☐ chronic cough	☐ recent weight loss	☐ anemia	☐ blood transfusion	☐ stroke
☐ fainting, black out	☐ seizures	☐ mental problem	☐ migraine headache	☐ nerve injury
☐ paralysis	☐ back injury	☐ herniated disc	☐ diabetes	☐ thyroid problems
☐ steroid use	☐ liver problems	☐ hepatitis	☐ hiatal hernia	☐ frequent heartburn
☐ ulcers	☐ kidney problems	☐ arthritis	☐ cancer	☐ chemotherapy
☐ radiotherapy	☐ loose or chipped teeth	☐ dentures or false teeth	☐ neck pain or stiffness	☐ hoarseness
☐ difficulty opening mouth				

Tobacco: no / yes amount ____________

Alcohol: no / yes amount ____________

Recreational drugs: no / yes amount ____________

Have you ever been tested for AIDS or HIV? __________ Results ________

Could you be pregnant? no / yes Due Date ____________

Start date of last menstrual period: ____________

Medications (prescription or over the counter): ____________

Drug allergies & Type of Reaction: ____________

Current medical problem/Why are you having this surgery?:. ____________

List any medical problems not listed above: ____________

List previous surgery/anesthetics: ____________

Problems with anesthesia: no / yes Describe: ____________

Family history of problems with anesthesia or surgery: no / yes ____

Latex Allergy: Yes ☐ No ☐ **ADVANCED DIRECTIVE EXECUTED ☐ Yes ☐ No**

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge. I am aware that my answers could affect my healthcare.

Signature of patient, parent or guardian: ____________ Date: ________ Relationship to patient: ____________

Questionnaire reviewed with patient/family, patient's history and health status as noted above. ☐

Signature of nurse: ____________

NURSING ASSESSMENT (to be completed by nurse or CRNA)

Additional notes by nurse: ____________

☐ I have made additional comments on back. Contact Lens ☐ No ☐ Yes

Signature of nurse: ____________ Date/time: ____________

age: ______ height: _____ weight: _____ BP: _____ P: _____ R: _____ T: _____ O_2 Sat RA: ______ VS obtained by: ________

ANESTHESIA PREOP EVALUATION (to be completed by anesthesiology personnel)

Questionnaire reviewed with patient/family, patient's history and systems review as noted above.

Additional comments by anesthesia including pertinent findings from history, physical exam, and diagnostic tests.

Lab results: Glucose ____________ **HCG** ____________

Impression: ASA Classification 1 2 3 4 5 E

NPO status: ____________

Airways: ____________

Problem list: ____________

Plan: ____________

Premed: ____________

Monitors: routine ____________

I have discussed anesthetic plan and risks with patient (or responsible party); questions invited and answered. Patient understands and consents.

☐ I have made additional comments on back

Anesthesiologist: ____________ Date/time: ____________