

PRESURGICAL AND ANESTHESIA EVALUATION CHECKLIST

Please answer the following questions. These responses will help us provide the best possible care for you.

CARDIAC	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you experienced anginal chest pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a heart condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a heart attack?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a heart murmur?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had heart failure?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have hypertension (high blood pressure)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a pacemaker or Defibrillator?

NEURO	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have back or neck pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have numbness, weakness, or paralysis of your extremities?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any muscle or nerve disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had convulsions, seizures or epilepsy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a stroke? TIA?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you experienced headaches, dizziness, light-headedness, or fainting?

RESPIRATORY	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you experience shortness of breath?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have asthma, bronchitis, or any other breathing problem?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have sleep apnea? CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you (or did you) smoke? Packs per day _____ # of Years _____ Date you quit _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you recently had a cold or the flu?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a chronic or productive cough?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have or have you had Tuberculosis?

SOCIAL	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcohol? # per week:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take or have you taken recreational/street drugs?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use Herbal Medications, home remedies or over the counter medications?

GI/GU	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had hepatitis, liver disease, or jaundice?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have ulcers, reflux, or other stomach disorders?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a hiatal hernia?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a recent weight gain or weight loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have or have you had kidney problems or have you had dialysis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Crohn's Disease or Irritable Bowel Disease?

ALLERGIES:	
Please describe reactions:	
<input type="checkbox"/> No known allergies	
<input type="checkbox"/> Latex <input type="checkbox"/> Environmental (Soap, dyes, etc.)	
Food: <input type="checkbox"/> Kiwi <input type="checkbox"/> Guava <input type="checkbox"/> Soy Bean <input type="checkbox"/> Eggs	
Medication Allergies:	

OTHER	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a thyroid condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have or have you had an infectious disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have diabetes? Insulin pump? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have arthritis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any bleeding problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take blood thinners, (Coumadin, Aspirin, Plavix, Ticlid, etc?) Last date taken:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have/or have you had cancer?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or any blood relatives had difficulties with anesthesia?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have loose, chipped, false teeth, or bridgework?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contact lenses/glasses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you wear a hearing aid?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Females Only: Are you pregnant? Last menstrual date: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any skin problems (presently)?

SURGERIES/HOSPITALIZATIONS/ADDITIONAL INFO:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Describe:

LIVING WILL/POWER OF ATTORNEY	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a living will?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a power of attorney?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like information on living will?

Patient's Signature:	
	Date: _____

TO BE COMPLETED BY BSC STAFF: VITAL SIGNS	
Blood Pressure: _____	Height: _____
Pulse: _____	Weight: _____
Respirations : _____	
Temperature: _____	
Pulse Oximetry: _____	

Presurgical & Anesthesia Evaluation Reviewed by:	
RN: _____	Date: _____
CRNA: _____	Date: _____

LABEL	