SURGERY PARTNERS

# Pre-Anesthesia Assessment

The amount of medication given to you during your procedure is adjusted according to your height and weight.

Current: Height? _____ Weight? _____ Age? _____

Have you had surgery before? Yes ☐ No ☐ If so, when and what kind of surgery?

_____

_____

Have you or any members of your family had problems, INCLUDING FEVER, with prior anesthetics?(blood rel)

Yes ☐ No ☐ If yes, explain: _____

_____

Have you had any drug reactions or drug allergies? Yes ☐ No ☐: If so , please list

_____

**Circle** if you have anyof the following allergies: Latex Iodine/Betadine Seafood/Shellfish Morphine/Demerol Sulfur/Eggs IVP dye

| Do you have or have you had any of the following? | Yes | No | If Yes, give additional information |
|---|---|---|---|
| A. Thyroid or goiter problems | | | |
| B. Diabetes or hypoglycemia | | | |
| C. Epilepsy or seizures | | | |
| D. High blood pressure or stroke | | | |
| E. Heart disease or mitral valve prolapse | | | |
| F. Chest pain or angina | | | |
| G. Lung disease or emphysema | | | |
| H. Chronic cough, asthma, or shortness of breath | | | |
| I. Hepatitis cirrhosis or jaundice | | | |
| J. Kidney disease | | | |
| K. Ulcers or hiatel hernia | | | |
| L. Anemia or sickle cell disease. | | | |
| M. Recent weight loss | | | |

Are you now or have you ever been in a drug recovery program? Yes ☐ No ☐

Do you drink more than 2 alcoholic beverages daily? Yes ☐ No ☐ If so, how many?

Do you smoke? Yes ☐ No ☐ If yes, _____Packs per day for _____ year

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ID / Visit: / DOS: 1/1/0001

DOB: Age:

SPACE COAST
SURGERY CENTER

| | Yes | No | Additional Information |
|---|---|---|---|
| Have you had broken facial bones? | | | |
| Have you had back, jaw, or nose surgery? | | | |
| Do you use eye drops or wear contact lenses? | | | |
| Do you have loose teeth, caps, crowns, or dentures? | | | |
| Have you had abnormal chest film or EKG? | | | |
| Do you have back trouble? | | | |
| Are you pregnant?<br>If not, when was your last period? | | | |
| Have you had a blood transfusion? | | | |
| Do you take blood-thinning medications? | | | |

Have you ever been diagnosed or told you are positive for HIV (virus that causes AIDS)? Yes No

Do you have any illnesses or medical condition not mentioned above (e.g. cancer, neurological, etc?) Yes No

Do you presently take any medications? If so, please list the medication you take and the amount and frequency:

_____

_____

_____

Do you take vitamins, herbal medications, or herbal drinks? If so, please list the amount and frequency

_____

Patient's or guardian's signature: Date:

Preadmission Screening Nurse _____ Date_____

BRAD Receieved Yes or No (circle) DPOA Yes or No (circle)

Anesthesia Care Provider's (ACP) ASA : See Anesthesia Record

**Respiratory**: Bi-laterally clear Yes No Other

**Cardiac:** Regular Rate & Rhythm, No Significant Murmur Yes No Other

_____

_____

**Anesthesia Care Provider's Signature:** _____ **Date:**_____

I have reviewed the anesthesia-related and procedural risks on this patient for this procedure

_____ Date_____ Time_____

Supervising physician signature if indicated

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DOB: Age: