

PREANESTHESIA EVALUATION		Age	Sex	Height	Weight
			M F	in / cm	lb / kg
Proposed Procedure		Pre-Procedure Vital Signs B/P P R T			
Previous Anesthesia / Operations		None <input type="checkbox"/>	Current Medications		None <input type="checkbox"/>
Family History of Anesthesia Complications		None <input type="checkbox"/>	Allergies		NKDA <input type="checkbox"/>
AIRWAY / TEETH / HEAD & NECK					History From: <input type="checkbox"/> Patient <input type="checkbox"/> Significant Other <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Chart <input type="checkbox"/> Communication / Language Problems <input type="checkbox"/> Poor Historian
SYSTEM	WNL	COMMENTS			DIAGNOSTIC STUDIES
RESPIRATORY	<input type="checkbox"/>	Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Packs / Day for _____ Years			EKG
Asthma Productive Cough Bronchitis Recent URI COPD SOB Dyspnea Tuberculosis Orthopnea Pneumonia					Chest X-ray
CARDIOVASCULAR	<input type="checkbox"/>				Pulmonary Studies
Abnormal EKG Hypertension Angina MI ASHD Murmur CHF Pacemaker Dysrhythmia Rheumatic Fever Exercise Tolerance Valvular Disease					Other
HEPATO / GASTROINTESTINAL	<input type="checkbox"/>	Ethanol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency _____ "Street Drug" Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency _____			
Bowel Obstruction Cirrhosis Hepatitis / Jaundice Hiatal hernia / Reflux Nausea & Vomiting Ulcers					
NEURO / MUSCULOSKELETAL	<input type="checkbox"/>				LABORATORY STUDIES
Arthritis Muscle Weakness Back Problems Neuromuscular Dis. CVA / Stroke / TIAs Paralysis DJD Paresthesia Headaches / ↑ ICP Syncope Loss of Consciousness Seizures					Hgb / Hct / CBC
RENAL / ENDOCRINE	<input type="checkbox"/>				Electrolytes
Diabetes Renal Failure / Dialysis Thyroid Disease Urinary Retention Urinary Tract Infection Weight Loss / Gain					Urinanalysis
OTHER					Other
Anemia Immunosuppressed Bleeding tendencies Pregnancy Cancer Sickle Cell Dis. / Trait Chemotherapy Recent Steroids Dehydration Transfusion History Hemophilia					
Problem List / Diagnoses		PHYSICAL STATUS	POSTANESTHESIA NOTE		
Planned Anesthesia / Special Monitors			1		
			2		
			3		
			4		
		5			
Pre-Anesthesia Medications Ordered		E	Signed _____ Date _____ Time _____		
Evaluator Signature		PATIENT IDENTIFICATION			
Date					
Time					