1. Please fill out the **SHADED** areas on the following two pages.

2. To ensure your safety and comfort during anesthesia, please fill it out thoroughly.
Do you have or have you had any of the following? Check all that apply

- High blood pressure
- Heart Attack / MI Date
- Chest pain / Angina
- ICD / Pacemaker Model
- Coumadin
- Lovenox
- EKG
- Cardiac Cath
- Asthma
- COPD / Emphysema
- Cough
- Sleep Apnea
- Diabetes
- Kidney Disease
- Liver Disease
- Difficulty swallowing
- Cancer
- Gastric Ulcer
- Thyroid Disease
- Seizures
- Arthritis
- Anemia
- Bleeding Problems
- Mental Illness
- Depression
- Other

Do you take blood thinners? Check all that apply

- Plavix
- Aspirin
- Lovenox
- Other

Have you had any of the following tests in the past? Complete all that apply

- EKG
- Stress Test
- Echo
- Cardiac Cath
- Pacemaker / Defibrillator
- Chest X-Ray

Do you have or have you had any of the following? Check all that apply

- Murmur
- Palpitations
- Irregular Heart Beat
- Dizziness / Fainting
- Open Heart Surgery
- Blood clots / Phlebitis

Do you take blood thinners? Check all that apply

- EKG
- Stress Test
- Echo
- Cardiac Cath
- Pacemaker / Defibrillator
- Chest X-Ray

Have you had any of the following tests in the past? Complete all that apply

- EKG
- Stress Test
- Echo
- Cardiac Cath
- Pacemaker / Defibrillator
- Chest X-Ray

Do you have or have you had any of the following? Check all that apply

- Cold or Flu past 2 weeks
- Bronchitis
- Pneumonia past 2 months
- Oxygen at home
- Stop breathing in your sleep
- Have daytime sleepiness

Do you have or have you had any of the following? Check all that apply

- Renal Failure
- Insufficiency
- Stones
- Heart Attack / MI Date
- Renal Failure
- Insufficiency
- Stones
- Cancer? If yes, type
- Date
- TIA
- Blood products refused

PATIENT NAME

DATE OF BIRTH

PLACE PATIENT ID LABEL HERE
Scheduled procedure: ________________________________

Do you have any of the following?
- Dentures
- Crowns
- Caps
- Bridge
- Loose, chipped, or broken teeth
- Contacts
- Glasses
- Cataracts
- Glaucoma
- Eye Implants
- Cochrane implant
- Insulin pump
- Pain Pump
- Other Implant
- Total joint/prosthesis: Type
- ASA classification: 1 2 3 4 5 E
- Height _______ Weight _______

HX:

Pertinent Labs/Pertinent Diagnostics:

Physical:
- Lungs: CTA
- Heart: RRR
- Airway: Adequate

ASA Classification: 1 2 3 4 5 E

Nursing Only:
- Anesthesia Coordinator consulted
- Old anesthesia record (if needed)
- SMH Date _______
- Other _______ Date _______
- Sent for
- On chart
- Preg screen ordered
- Reason not ordered: Age > 60
- Hyst
- Meno

Airway:
- Adequate
- Other

Yes No
- Have you or a blood relative ever had a problem with anesthesia?
- Have you ever been told you had a difficult intubation?
- Do you have a history of motion sickness or nausea/vomiting after surgery?
- Are you being treated for a chronic pain condition?
- Are you sensitive to pain medication or sleeping pills?
- Are you claustrophobic or do you have an anxiety condition?
- Do you consume alcohol? How much?
- Do you use recreational drugs? Occasionally
- Do you smoke or did you ever smoke? How many years?
- How much? 1 1/2 pack/day
- When did you quit?
- If female, are you pregnant or think you could be?
- Last menstrual period?
- Do you have difficulty walking? Do you use? Cane Walker Wheelchair
- Do you have difficulty walking two blocks at a normal pace?
- Do you have difficulty walking up two flights of stairs?
- Do you sleep on more than one pillow?
- Do you wake up suddenly short of breath?
- Are you currently in a drug study? Name of drug

Form completed by: Patient Other:

ANESTHESIA COORDINATOR (if applicable)

Form reviewed by: ____________________ Date _______

Date _______ (Surgical Date)
- BP _______ P _______ R _______
- Temp _______ O2 Sat _______
- Accuchek _______ Time _______

Form Reviewed by: ____________________ Date _______

STOP, Section below for M.D. use only

Preoperative Anesthesiologist: ____________________ Date _______ Time _______

SARASOTA MEMORIAL HEALTH CARE SYSTEM
ANESTHESIA PRE-OPERATIVE ASSESSMENT