

Name: _____ HT: _____ WT: _____ in Kg

Surgeon: _____ DOS _____ DOB _____

CARDIAC

- | Yes | No | |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina/Chest Pain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | CHF - Congestive heart failure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart catheterization / stent _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ECHO/EKG _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stress test _____ |

Cardiologist's Name _____

Phone No. _____

CIRCULATORY

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | PVD - Peripheral Vascular Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding/clotting disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Thinners: Coumadin / ASA / NSAIDS _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia _____ |

LUNGS

- | | | |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Smoker # of years _____ ppd _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold/cough _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic bronchitis / emphysema _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep apnea _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis _____ |

NEURO

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headache _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness/numbness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | TIA / stroke _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimers / confusion _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cervical spine disease _____ |

MUSCULO-SKELETAL

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Myasthenia gravis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

ENDOCRINE / RENAL

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes <input type="checkbox"/> Insulin <input type="checkbox"/> Oral <input type="checkbox"/> Diet _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Renal Failure / Dialysis _____ |

EENT

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Crowns <input type="checkbox"/> Bridgework |
| <input type="checkbox"/> | <input type="checkbox"/> | Dentures <input type="checkbox"/> Upper _____ <input type="checkbox"/> Lower _____ |

GI

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn / reflux / Peptic ulcer disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis history _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol consumption _____ |

REPRODUCTIVE

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? _____ LMP _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tubal Ligation / hysterectomy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Post menopausal _____ |

***CHILDREN ONLY:**

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Prematurity _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | History of apnea _____ <input type="checkbox"/> RSV <input type="checkbox"/> BPD |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease _____ |

MEDICATIONS: (Prescriptions, over-the-counter drugs, vitamins, minerals, herbs and diet pills, recreation/IV drugs)

ALLERGIES: (Medications, food, latex, adhesives, iodine)

PRIOR SURGERIES

ANESTHESIA PROBLEMS

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult intubation _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea/vomiting _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever _____ <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Relatives with anesthetic problems _____ |

OTHER MEDICAL HISTORY

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Is this due to an accidental injury? If yes, date: _____ |
|--------------------------|--------------------------|---|

R.N. SIGNATURE: _____ DATE: _____

PHYSICAL EXAM FOR OFFICE USE ONLY

| HISTORY OF PRESENT ILLNESS: _____ | ANESTHESIA PROBLEM LIST - ASA PHYSICAL STATUS _____ |
|-----------------------------------|---|
| HEENT: _____ | _____ |
| CHEST, LUNGS: _____ | _____ |
| HEART: _____ | _____ |
| ABDOMEN: _____ | _____ |
| EXTREMITIES: _____ | _____ |
| NEURO: _____ | _____ |

I HAVE EVALUATED THE PATIENT AND DISCUSSED THE PROCEDURE AND RISKS FOR THE PROPOSED ANESTHETIC WITH THE PATIENT WHO HAS INDICATED HIS OR HER UNDERSTANDING AND ACCEPTANCE.

ANESTHESIOLOGIST'S SIGNATURE: _____ DATE: _____

I HAVE REVIEWED THIS PATIENT'S HISTORY AND PHYSICAL AND HE/SHE IS ACCEPTABLE FOR SURGERY.

ATTENDING SURGEON'S SIGNATURE: _____ DATE: _____

