

PREANESTHESIA EVALUATION				Age	Sex M F	Height in / cm	Weight 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						<b>History From:</b> <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					
<b>RESPIRATORY</b> Asthma                      Productive Cough Bronchitis                Recent URI COPD                        SOB Dyspnea                    Tuberculosis Orthopnea Pneumonia	<input type="checkbox"/>	Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No      _____ Packs / Day for _____ Years	EKG  Chest X-ray  Pulmonary Studies  Other					
<b>CARDIOVASCULAR</b> Abnormal EKG            Hypertension Angina                    MI ASHD                      Murmur CHF                        Pacemaker Dysrhythmia              Rheumatic Fever Exercise Tolerance      Valvular Disease	<input type="checkbox"/>							
<b>HEPATO / GASTROINTESTINAL</b> Bowel Obstruction Cirrhosis Hepatitis / Jaundice Hiatal hernia / Reflux Nausea & Vomiting Ulcers	<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 _____						
<b>NEURO / MUSCULOSKELETAL</b> Arthritis                    Muscle Weakness Back Problems            Neuromuscular Dis. CVA / Stroke / TIAs      Paralysis DJD                         Paresthesia Headaches / ↑ ICP        Syncope Loss of Consciousness    Seizures	<input type="checkbox"/>							
<b>RENAL / ENDOCRINE</b> Diabetes Renal Failure / Dialysis Thyroid Disease Urinary Retention Urinary Tract Infection Weight Loss / Gain	<input type="checkbox"/>							
<b>OTHER</b> Anemia                      Immunosuppressed Bleeding tendencies      Pregnancy Cancer                      Sickle Cell Dis. / Trait Chemotherapy              Recent Steroids Dehydration                Transfusion History Hemophilia	<input type="checkbox"/>							
Problem List / Diagnoses			<b>POSTANESTHESIA NOTE</b>     Signed _____ Date _____ Time _____					
Planned Anesthesia / Special Monitors								
Pre-Anesthesia Medications Ordered								
Evaluator Signature								
Date								
Time			PATIENT IDENTIFICATION					