Huntington Hospital

Pre-Anesthesia Evaluation (Part 1)

DATE:_____ TIME:_____ PRIMARY LANGUAGE: ❑ English ❑ Spanish Other: _____

PATIENT: _____

SURGEON:_____ SURGERY: _____

YOUR PRIMARY DOCTOR: _____ OFFICE # (___) _____

OTHER SPECIALISTS: _____

INSTRUCTIONS TO PATIENT: This questionnaire will help your Anesthesiologist select the proper anesthetic for you. Please check the appropriate boxes and fill-in needed information.

YOUR MEDICAL HISTORY:

❑ No ❑ Yes Have you ever had a transfusion of blood or blood products? If yes, when?_____

❑ No ❑ Yes If medically necessary, would you accept a blood transfusion?

❑ No ❑ Yes For women, currently pregnant? If yes, # of weeks _____ If no, Last menstrual period: _____

❑ No ❑ Yes Do you now, or did you ever smoke? How much? _____ How long? _____ When did you quit? _____

❑ No ❑ Yes Do you drink alcohol? Type?_____ How much?_____ How often? _____

❑ No ❑ Yes Have you ever had alcoholic withdrawal (DT's)?

❑ No ❑ Yes Do you use any illicit or recreational drugs? If yes, describe: _____

❑ No ❑ Yes Is there any possibility that you have any communicable diseases at this time?

❑ No ❑ Yes Have you traveled outside of the U.S. in the past two years? If so, where? _____

❑ No ❑ Yes Has anyone in your family had a tendency to bleed excessively? If yes, explain:_____

_____

❑ No ❑ Yes Has anyone in your family had unusual reactions or problems with anesthesia? If yes, explain: _____

_____

❑ No ❑ Yes Has anyone in your family had unexplained fevers during or following surgery? _____

PLEASE CHECK THE BOX IF YOU EVER HAD THE FOLLOWING AND ENTER THE DATE

	MONTH / YEAR		MONTH / YEAR		MONTH / YEAR
❑ Heart disease	_____	❑ Diabetes	_____	❑ Neurological disease	_____
❑ Heart murmur	_____	❑ Asthma or frequent wheezing	_____	❑ Back pain / problems	_____
❑ Prolapsed mitral valve	_____	❑ Emphysema	_____	❑ Hepatitis (Yellow jaundice)	_____
❑ Heart attack	_____	❑ Bronchitis	_____	❑ Blood clots	_____
❑ Palpitations (irregular heart beat)	_____	❑ Recent pulmonary function tests	_____	❑ Easy bruising or bleeding	_____
❑ Chest pain	_____	❑ Sleep Apnea	_____	❑ Sickle Cell disease	_____
❑ Recent cardiac studies (stress test, echo, wall motion)	_____	❑ Tuberculosis	_____	❑ Cancer	_____
❑ High blood pressure	_____	❑ Stroke	_____	❑ AIDS / HIV	_____
❑ Wake up at night with shortness of breath	_____	❑ Frequent headaches	_____	❑ Serious illness during pregnancy	_____
❑ Kidney disease	_____	❑ Fainting spells	_____	❑ Glaucoma	_____
❑ Thyroid disease	_____	❑ Epilepsy / Seizures	_____		
		❑ Chicken Pox / Shingles	_____		

Comments: _____

_____

PHYSICAL ACTIVITY NOW: ❑ None ❑ Little ❑ Moderate ❑ Very Active

Can you climb stairs? ❑ No ❑ Yes, number of flights? ❑ 1 ❑ 2 ❑ 3 ❑ 3+

Medical History / Illnesses requiring Hospitalization: List & Date: _____

_____

_____

Previous Surgeries / Procedures (Including pacemaker, AICD, implants etc: List & Date: _____

_____

_____

_____

ANESTHESIA HISTORY: Check the box of the kind(s) of Anesthesia you have had before:

❑ Local or nerve block ❑ Epidural ❑ Spinal ❑ General (completely asleep)

❑ Sedation Analgesia / "Conscious sedation" or "Twilight Sleep" (e.g., during colonoscopy, teeth exaction etc.)

Have you had any unusual reactions, problems, or complications with anesthesia (e.g., jaundice, high fever, paralysis, breathing problems, required placement on a ventilator, etc.) ❑ No ❑ Yes, explain: _____

_____

PHYSICAL INFORMATION: **DO YOU WEAR / HAVE...?**

❑ No ❑ Yes Glasses ❑ No ❑ Yes Contact Lenses ❑ No ❑ Yes False Eyelashes

❑ No ❑ Yes Removable Dentures / Partials

❑ No ❑ Yes Non-removable dental work, such as a veneer, crown/cap, bridge, post and/or implant

❑ No ❑ Yes Loose or chipped teeth

❑ No ❑ Yes Current dental work in-progress

❑ No ❑ Yes Difficulty with movement of your head or neck

❑ No ❑ Yes False eye(s)

❑ No ❑ Yes Major physical or congenital defect(s): Please explain:_____

❑ No ❑ Yes Difficulty opening your mouth

❑ No ❑ Yes Difficulty hearing ❑ No ❑ Yes Do you wear hearing aids?

ALLERGIES / DRUG REACTIONS:

❑ No ❑ Yes Latex Allergy / Intolerance: Explain: _____

❑ No ❑ Yes Medication Allergies / Intolerances: List & explain: _____

_____

❑ No ❑ Yes Food Allergies / Intolerances: List & explain: _____

_____

❑ No ❑ Yes Contrast Media (Iodine Dye) Reaction: Explain: _____

CURRENT MEDICATIONS: **INCLUDING "OVER-THE-COUNTER" AND HERBAL MEDICATIONS** ❑ See attached list

List names & doses of any medications / herbals you take now or have taken in the last 6 months.

_____

_____

_____

_____

_____

X _____ _____

PATIENT / RESPONSIBLE PARTY SIGNATURE RELATIONSHIP

_____ _____

DATE INTERPRETER, IF APPLICABLE

FOR HOSPITAL USE ONLY:

DATE:_____ NURSE SIGNATURE:_____

WT:_____ HT:_____ BP:_____ HR:_____ RR:_____ TEMP:_____