Rev-04/8/2023

DOCTORS' SAME DAY SURGERY CENTER
PRE-OPERATIVE ANESTHESIA EVALUATION

PATIENT'S NAME: _____ ***MALE***:□ ***FEMALE***:□ ***TODAY'S DATE***: _____

DATE OF BIRTH: _____ ***AGE***: _____ ***HEIGHT***: _____ Feet _____ Inches ***WEIGHT***: _____ bs.

PROCEDURE: _____ ***DATE OF PROCEDURE***: _____

SURGEON: _____ ***PRIMARY CARE DOCTOR***: _____

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ALLERGIES CHECK & EXPLAIN

DRUG	***REACTION***	***DRUG***	***REACTION***

Iodine/IV Contrast □ *Reaction:* _____

Tape/Adhesive □ *Reaction:* _____ ***Latex / Rubber*** □ *Reaction:*

List Food/Environmental □ _____ *Reaction:* _____

DENTAL WORK CHECK

TEETH: ***Full Dentures*** *Top* □ *Bottom* □ ***Partial Dentures*** *Top* □ *Bottom* □ ***Bridges*** *Top* □ *Bottom* □

Caps Crowns *Front Top* □ *Front Bottom* □ *Sides* □ ***Veneers*** □ ***Retainers*** *Top* □ *Bottom* □

Braces □ ***Loose*** □ ***Broken*** □ ***Missing*** □ ***Implants*** □ ***TMJ*** □

SMOKING / ALCOHOL / DRUG ABUSE CHECK

SMOKING- ***Cigarettes*** □ ***Cigars*** □ *Number/Day:* _____ *Number of Years:* _____ *if* ***Quit*** □ *When:* _____

Chew □ ***Snuff*** □ ***Vape*** □ *How many years:* _____

Alcohol □ *Number of Drinks* _____ *Per Day* □ *Per Week* □ *Per Month* □

Marijuana □ *How often:* _____ *Last Use:* _____

Street Drugs □ *When:* _____ *What Drugs:* _____

PAST SURGERIES/PROCEDURES LIST STARTING WITH LAST

RECENT HOSPITALIZATION, ER/URGENT CARE VISIT *Why*: _____

_____

_____

Rev-04/8/2023

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ANESTHESIA COMPLICATIONS CHECK & EXPLAIN

WITH YOU □	***WITH YOUR BLOOD RELATIVE*** □		
Nausea/Vomiting □	***Difficult Airway*** □	***Difficult Intubation*** □	***Malignant Hyperthermia*** □
Prolonged Paralysis □	***Difficulty Breathing*** □		
Any other Complication □ *Explain*:			

MISCELLANEOUS CHECK/CIRCLE

BLOOD THINNERS		***YES***	***NO***	*Why:*		
BETA BLOCKERS		***YES***	***NO***			
BLOOD TRANSFUSION		***YES***	***NO***	*When:* *Why:*		
PROSTHESIS □ ***HARDWARE*** □ ***IMPLANTS***□		***YES***	***NO***	*Location:*		
CONTACT LENSES		***YES***	***NO***	*Sleep with contact lenses in*	***YES***	***NO***
HARD OF HEARING		***YES***	***NO***	*Hearing Aid in*	***YES***	***NO***
Chemo Port □ ***Picc Line*** □ ***Dialysis Access*** □		***YES***	***NO***	*Location:*		
PAIN PUMP □ ***INSULIN PUMP*** □ ***SCS*** □		***YES***	***NO***	*Location:*		
PREGNANT	***N/A***	***YES***	***NO***	*What trimester:*		
BREAST FEEDING	***N/A***	***YES***	***NO***	*Discussed with Ob/Gyn*	***YES***	***NO***
LAST MENSTRUAL CYCLE	***N/A***	*Date:*				

NEURO/EYES/EARS/NOSE/THROAT CHECK/CIRCLE Do you See a **Neurologist** □

STROKE	***YES***	***NO***	*When:* *Loss of Function:*		
TIA *(Mini Stroke)*	***YES***	***NO***	*When:*		
BRAIN ANEURYSM	***YES***	***NO***	*When:* *Surgery/Clipping*	***YES***	***NO***
EPILEPSY □ ***SEIZURES*** □	***YES***	***NO***	*Last Seizure:*		
MULTIPLE SCLEROSIS	***YES***	***NO***	***DEMENTIA/ALZHEIMERS***	***YES***	***NO***
NOSE BLEEDS	***YES***	***NO***	***NASAL POLYPS***	***YES***	***NO***
RETINAL DETACHMENT	***YES***	***NO***	*Surgery:*	***YES***	***NO***
Dry Eyes □ ***Glaucoma*** □ ***Cataract*** □	***YES***	***NO***	*Surgery:*	***YES***	***NO***

HEMATOLOGY(BLOOD RELATED) CIRCLE Do you See a **Hematologist/Oncologist** □

ANEMIA	***YES***	***NO***	***BRUISE EASILY***	***YES***	***NO***
BLEEDING DISORDER	***YES***	***NO***	*Specify:*		
SICKLE CELL TRAIT	***YES***	***NO***	***SICKLE CELL DISEASE***	***YES***	***NO***
Gene Mutation (Clotting disorder)	***YES***	***NO***	*Type:*		

Rev-04/8/2023

DOCTORS' SAME DAY SURGERY CENTER
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PULMONARY (LUNGS) CHECK/CIRCLE Do you See a **Pulmonary Doctor**:□

Recent - ***Pneumonia***□ ***Cold***□ ***Flu***□ ***URI***□	***YES***	***NO***			
Asthma□ ***Bronchitis***□ ***COPD***□ ***Emphysema***□	***YES***	***NO***	***REACTIVE AIRWAY DISEASE***	***YES***	***NO***
CHRONIC COUGH	***YES***	***NO***	*Productive □ Non-Productive □*		
USE OXYGEN AT HOME	***YES***	***NO***	*How Many Liters:*		
USE INHALERS/NEBULIZER	***YES***	***NO***	*Last Use:*		
SLEEP APNEA	***YES***	***NO***	*CPAP □ BIPA P□ APAP □ NONE □*		
PULMONARY FIBROSIS	***YES***	***NO***	***PULMONARY HYPERTENSION***	***YES***	***NO***
SARCOIDOSIS	***YES***	***NO***	***H/O TUBERCULOSIS***	***YES***	***NO***

ENDOCRINE (GLANDS) CHECK/CIRCLE Do you See an **Endocrinologist** □

Thyroid problem□ ***Thyroid Nodules***□	***YES***	***NO***	*Low Hormone (**Hypo**) □*	*High Hormone (**Hyper**)□*	
PRE-DIABETES or DIABETES	***YES***	***NO***	***Diabetic Neuropathy***	***YES***	***NO***
H/O HYPOGLYCEMIA	***YES***	***NO***	*DM Type I □ DM Type II □*		
PITUIATRY PROBLEM	***YES***	***NO***	***ADRENAL PROBLEM***	***YES***	***NO***

CHECK/CIRCLE

VASCULAR/CARDIOVASCULAR Do you See **Vascular Doctor** □ **Cardiologist** □

BLOOD CLOTS *(DVT)*	***YES***	***NO***	*When:*				
PULMONARY EMBOLUS *(PE)*	***YES***	***NO***	*When:*				
GREENFIELD FILTER *(IVCF)*	***YES***	***NO***					
POOR CIRCULATION LEGS *(PAD/PVD)*	***YES***	***NO***	***BYPASS SURGERY/STENTS***			***YES***	***NO***
HYPERTENSION	***YES***	***NO***	*Run Low BP / BP Drops When Standing*			***YES***	***NO***
ANGINA *(CHEST PAIN)*	***YES***	***NO***	*How Often:*				
CORONARY BLOCKAGES *(CAD)*	***YES***	***NO***	*Last Chest Pain:*	*Relieved by NTG□ REST□*			
HEART ATTACK *(MI)*	***YES***	***NO***	*Coronary Bypass When**:***	*How Many Vessels**:***			
CORONARY STENTS/ANGIOPLASTY	***YES***	***NO***	*How Many:*	*Last Stent Date:*			
CONGESTIVE HEART FAILURE *(CHF)*	***YES***	***NO***	*Ever Hospitalized for CHF:*				
SHORTNESS OF BREATH *(SOB)*	***YES***	***NO***	*With Exertion □*	*At Rest □*			
WAKE UP WITH SOB	***YES***	***NO***	*How many Pillows do you use to sleep**:***				
SWELLING OF FEET	***YES***	***NO***	*Take Fluid Pill*			***YES***	***NO***
IRREGULAR HEART RATE	***YES***	***NO***	*Slow □ Fast □ Palpitation**s** □ Skipping Beats □ PVC's □ A-Fib □ SVT □ V-Tach □ WPW □*				
CAROTID ARTERY DISEASE	***YES***	***NO***	*Right □ % Blockage:_*	*Left □ % Blockage:*			
CAROTID ARTERY SURGERY	***YES***	***NO***	*Right □ Left □*				
HEART VALVE PROBLEM	***YES***	***NO***	*Surgery:*				
HEART MURMUR	***YES***	***NO***	***H/O RHEUMATIC FEVER***			***YES***	***NO***
MITRAL VALVE PROLAPSE *(MVP)*	***YES***	***NO***	*Symptoms Chest pain □ SOB □ Palpitation □*				
PACEMAKER □ ICD □ COMBINED □	***YES***	***NO***	*Last Check:*				
ABDOMINAL AORTIC ANURYSM -*AAA*	***YES***	***NO***	*Size:*	*Last Check:*	*Surgery:*	***YES***	***NO***
CARDIOLOGY VISIT DATE: *____ EKG□ Stress test□ Echo□ Cath□ CT□ Loop recorder/Holter□*							

Rev-04/8/2023

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GASTROINTESTINAL/ LIVER:

Do you See **GI Doctor** □ or **Hepatologist** □

JAUNDICE	***YES***	***NO***	***HEPATITIS*** *A:□ B:□ C:□*	*Treated:*	***YES***	***NO***
FATTY LIVER	***YES***	***NO***		***CIRROSIS OF LIVER***	***YES***	***NO***
WEIGHT LOSS SURGERY	***YES***	***NO***	*Weight before Surgery:*	*Weight After:*		
REFLUX/GERD	***YES***	***NO***		***H/O ULCERS***	***YES***	***NO***
HIATAL HERNIA	***YES***	***NO***				
GASTRITIS □ ***CROHNS*** □ ***DIVERTICULITIS*** □ ***IBD/IBS*** □ ***GASTROPARESIS*** □					***YES***	***NO***

NEPHROLOGY /UROLOGY

Do you See a **Urologist** □ **Nephrologist** □

CHRONIC KIDNEY DISEASE *(CKD)*	***YES***	***NO***	*Stage:* ***I:***□ ***II:***□ ***III:***□ ***IV:***□		
DIALYSIS	***YES***	***NO***	*Fistula*□ *Peritoneal*□ *Catheter*□		
KIDNEY STONES	***YES***	***NO***	***GOUT***	***YES***	***NO***
ENLARGED PROSTATE	***YES***	***NO***	***OVERACTIVE BLADDER***	***YES***	***NO***
Sexually transmitted diseases (STD's)	***YES***	***NO***			

MUSCULOSKELETAL /CHRONIC PAIN

Do you See a **Pain Management Doctor** □

OSTEOARTHRITIS	***YES***	***NO***	***RHEUMATOID ARTHRITIS***	***YES***	***NO***
MYASTHENIA GRAVIS	***YES***	***NO***	***MUSCULAR DYSTROPHY***	***YES***	***NO***
MUSCULAR DYSTROPHY	***YES***	***NO***	*Type:*		
Do you have ***Abdominal Wall Hernia*** □ ***Belly Button Hernia*** □ ***Groin Hernia*** □				***YES***	***NO***
FIBROMYALGIA	***YES***	***NO***	***H/O FREQUENT FALLS***	***YES***	***NO***
DISC PROBLEM	***YES***	***NO***			
Numbness□ ***Tingling***□ ***Weakness***□	***YES***	***NO***	*Location:*		
H/O PAIN	***YES***	***NO***	*Location:*		

INFECTIOUS / CANCER / PSYCH

CIRCLE

Do you See a **Psychiatrist** □

H/O COVID	***YES***	***NO***	*When:*	*Residual Symptoms*	***YES***	***NO***
H/O MRSA	***YES***	***NO***		***H/O HIV/AIDS***	***YES***	***NO***
H/OANXIETY	***YES***	***NO***		***H/O DEPRESSION***	***YES***	***NO***
H/O PTSD	***YES***	***NO***		***H/O PANIC ATTACKS***	***YES***	***NO***
SUICIDE THOUGHTS	***YES***	***NO***				
H/O CANCER	***YES***	***NO***	*Type of Cancer:*			
ANY OTHER ILLNESS-						

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PATIENT'S SIGNATURES: _____ **DATE:** _____

NAME OF PERSON ANSWERING: _____ **RELATION TO THE PATIENT:** _____

RRVIEWED BY (RN): _____ **DATE:** _____ **TIME:** _____

Rev-04/8/2023

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PRE-OPERATIVE ANESTHESIA EVALUATION

FOR ANESTHESIA PROVIDER:

SURGEON'S REQUEST FOR ANESTHESIA:
CLEARANC REQUESTED YES □ NO □ FROM:
ANESTHESIA PLAN & POST-OP PAIN MANAGEMENT BLOCK:
□ GENERAL □ MAC/LOCAL □ MAC ONLY □ LOCAL ONLY
□ EPIDURAL □ BIER BLOCK □ AXILLARY/SUPRACLAVICULAR □ INTERSCALENE
□ SPINAL □ ADDUCTOR CANAL/SAPHENOUS □ POPLITEAL □ OTHER
NOTE:
EVALUATING ANESTHESIOLOGIST: **DATE:** **TIME**: