DOCTORS' SAME DAY SURGERY CENTER
PRE-OPERATIVE EVALUATION

NAME: _____ **MALE**:☐ **FEMALE**:☐ **TODAY'S DATE**: __/__/____

DATE OF BIRTH: __/__/____ **AGE**: ____ **HEIGHT**: ____ Feet ____ Inches **WEIGHT**: ____ Lbs.

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

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

ALLERGIES

CHECK & EXPLAIN

DRUG	REACTION	DRUG	REACTION
1		3	
2		4	

IV Iodine☐ **IV Contrast**☐ *Reaction:* _____

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

Foods☐ **Egg Yolk**☐ **Egg White**☐ **Environmental**☐ *List/Explain* _____

DENTAL WORK

CHECK BOXES

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

Caps/Crowns *Front Top*☐ *Front Bottom*☐ *Sides*☐ **Veneers**☐ **Retainers** *Top*☐ *Bottom*☐

Braces *Top*☐ *Bottom*☐ **Loose**☐ **Broken/Cracked**☐ **Missing**☐ **Implants**☐

SMOKING / ALCOHOL / DRUG ABUSE

CHECK BOXES

TOBACCO **Cigarettes**☐ **Cigars**☐ *How many per Day:* ____ *How Long:* ____ *if* **Quit**☐ *When:* ____

Chew☐ **Snuff**☐ **Vape**☐ *For How long:* ____

ALCOHOL☐ *Number of* **Drinks** _____ *Per Day*☐ *Per Week*☐ *Per Month*☐

MARIJUANA☐ *How often:* _____ *Last Use:* _____

STREET/PRESCRIBED DRUGS ABUSE☐ *When:* _____ *What:* _____

PAST SURGERIES & PROCEDURES UNDER ANESTHESIA

LIST STARTING WITH LAST

1	4	7
2	5	8
3	6	9

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

DOCTORS' SAME DAY SURGERY CENTER
PRE-OPERATIVE EVALUATION

ANY ANESTHESIA RELATED COMPLICATIONS *CHECK BOXES & EXPLAIN*

WITH YOU □	**OR**	***WITH YOUR BLOOD RELATIVE*** □
NAUSEA/VOMITING □	***DIFFICULT AIRWAY*** □	***DIFFICULT INTUBATION*** □
MALIGNANT HYPERTHERMIA □	***PROLONGED PARALYSIS*** □	***DIFFICULTY BREATHING*** □
ANY OTHER COMPLICATION □ *Explain:*		

MISCELLANEOUS (Answer What is relevant) *CHECK/CIRCLE*

Do you take ***BLOOD THINNERS*** □		***BETA BLOCKERS*** □		*Why:*		
ANY ***SKIN CONDITION*** *NOW*		***YES***	***NO***	*What Condition:*		
History of ***BLOOD TRANSFUSION*** *in past*		***YES***	***NO***	*When:* *Why:*		
PROSTHESIS □ ***HARDWARE*** □ ***IMPLANTS*** □		***YES***	***NO***	*Where:*		
Do you wear ***CONTACT LENSES***		***YES***	***NO***	*Do you* ***Sleep with*** *contact lenses in*	***YES***	***NO***
Are you ***HARD OF HEARING***		***YES***	***NO***	***Hearing Aids*** *in*	***YES***	***NO***
Port □ ***Mid/Picc Line*** □ ***Dialysis Access*** □		***YES***	***NO***	*Where:*		
PAIN PUMP □ ***INSULIN PUMP*** □ ***SCS*** □		***YES***	***NO***	*Where:*		
Are you ***PREGNANT***	***N/A***	***YES***	***NO***	*What trimester:*		
Are you ***BREAST FEEDING***	***N/A***	***YES***	***NO***	*Did you Discuss with* ***Ob/Gyn***	***YES***	***NO***
LAST MENSTRUAL CYCLE	***N/A***	*Date:*				

NEURO / EYES / EARS / NOSE / THROAT *CHECK/CIRCLE*

Do you See a **Neurologist** □

STROKE □ ***TIA*** □				*When:* *Any Loss of Function:*		
History of ***EPILEPSY*** □ ***SEIZURES*** □				*Last Seizure:*		
H/O ***MULTIPLE SCLEROSIS*** □				*H/O* ***LUPUS*** □		*H/O* ***DEMENTIA*** □
History of ***BRAIN ANEURYSM***	***YES***	***NO***		*When Diagnosed:* *Surgery*	***YES***	***NO***
History of ***NOSE BLEEDS***	***YES***	***NO***		*Do you have* ***NASAL POLYPS***	***YES***	***NO***
History of ***RETINAL DETACHMENT***	***YES***	***NO***		*Surgery:*	***YES***	***NO***
H/O ***DRY EYES*** □ ***GLAUCOMA*** □ ***CATARACT*** □				***Surgery*** *for Glaucoma or Cataract*	***YES***	***NO***

HEMATOLOGY (BLOOD RELATED) *CHECK/CIRCLE*

Do you See a **Hematologist/Oncologist** □

History of ***SICKLE CELL TRAIT***	***YES***	***NO***	*History of* ***SICKLE CELL DISEASE***	***YES***	***NO***
History of ***ANEMIA***	***YES***	***NO***	*Do you* ***BRUISE EASILY***	***YES***	***NO***
Any ***BLEEDING DISORDER***	***YES***	***NO***	*Specify:*		
Any ***GENE MUTATION DISORDER*** *(Clotting disorder)* ***YES*** □ ***NO*** □ *Specify:*					

DOCTORS' SAME DAY SURGERY CENTER
PRE-OPERATIVE EVALUATION

PULMONARY (LUNGS)

CHECK/CIRCLE

Do you See a **Lung Doctor**:□

RECENT - **PNEUMONIA**□	**COLD**□	**FLU**□	**RESPIRATORY INFECTION** □		**Covid** □
H/O **ASTHMA**□	**BRONCHITIS**□	**COPD**□	**EMPHYSEMA**□		**REACTIVE AIRWAY DISEASE** □
History of **SARCOIDOSIS**	**YES**	**NO**	History of **TUBERCULOSIS**	**YES**	**NO**
Do you have History of **SLEEP APNEA**	**YES**	**NO**	**USE**: CPAP□ BIPAP□ APAP□ NONE□		
Do you have **CHRONIC COUGH**	**YES**	**NO**	Productive □	Non-Productive □	
Do you use **OXYGEN** at Home **YES**□ **NO**□ How Many Liters:			Use **INHALERS/NEBULIZER YES**□ **No**□		
SCARRING IN LUNGS Y□ **N**□			**PULMONARY HYPERTENSION** (Not same as high blood pressure) **Y**□ **N**□		

ENDOCRINE (GLANDS)

CHECK/CIRCLE

Do you See an **Endocrinologist**□

THYROID/PARATHYROID PROBLEM□ **NODULES**□			Low Thyroid (**Hypo**)□ High Thyroid (**Hyper**)□		
PRE-DIABETICS□	**DIABETIC**□	Type I □ Type II □	**DIABETIC NEUROPATHY Yes**□ **No**□		
History of **HYPOGLYCEMIA**	**YES**	**NO**	Do you take any **GLP-1 drug** for Wt. Loss /DM	**YES**	**NO**
History of **PITUIATRY PROBLEM**	**YES**	**NO**	History of **ADRENAL PROBLEM**	**YES**	**NO**

VASCULAR/CARDIOVASCULAR

CHECK/CIRCLE

Do you See **Vascular**□ **Cardiologist**□

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

DOCTORS' SAME DAY SURGERY CENTER
PRE-OPERATIVE EVALUATION

GASTROINTESTINAL / LIVER: *CHECK/CIRCLE*

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

History of **JAUNDICE**	YES	NO	**HEPATITIS A**:□ **B**:□ **C**:□	Treated:	YES NO
History of **FATTY LIVER**	YES	NO		**CIRRHOSIS OF LIVER**	YES NO
WEIGHT LOSS SURGERY	YES	NO	**Weight** before Surgery:	After Surgery:	
H/O **REFLUX/GERD**□			**GI ULCERS**□		**HIATAL HERNIA**□
GASTRITIS□ **DIVERTICULITIS**□			**IBD (Crohn's/Ulcerative Colitis**□	**IBS**□	**GASTROPARESIS**□

NEPHROLOGY /UROLOGY *CHECK/CIRCLE*

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

CHRONIC KIDNEY DISEASE (CKD)	YES	NO	Stage: **I**:□ **II**:□ **III**:□ **IV**:□		
Are you on **DIALYSIS**	YES	NO	**HOW**: Fistula□ Peritoneal□ Catheter□		
History of **KIDNEY STONES**	YES	NO	Do you have **GOUT**	YES	NO
History of **ENLARGED PROSTATE**	YES	NO	Do you have **OVERACTIVE BLADDER**	YES	NO
Do you have any **SEXUALLY TRANSMITTED DISEASE (STD's)** YES□ NO□					

MUSCULOSKELETAL /CHRONIC PAIN *CHECK/CIRCLE*

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

Do you have **OSTEOARTHRITIS**	YES	NO	**PSORIATIC / RHEUMATOID ARTHRITIS**	YES	NO
Do you have **MYASTHENIA GRAVIS**	YES	NO	Any **MUSCULAR DYSTROPHY**	YES	NO
Do you have **Belly Wall Hernia**□			**Belly Button Hernia**□		**Groin Hernia**□
Do have **FIBROMYALGIA**	YES	NO	History of **FREQUENT FALLS**	YES	NO
Do you have any **DISC PROBLEM**	YES	NO	What Level:		
Numbness□ **Tingling**□ **Weakness**□	YES	NO	Where:		
Do you have H/O **CHRONIC PAIN**	YES	NO	Where:		

INFECTIOUS / CANCER / PSYCH *CHECK/CIRCLE*

Do you See a **Psychiatrist**□

H/O **MRSA**□ **VRE**□	YES	NO	H/O **HIV/AIDS**	YES		NO
H/O Any **CANCER**	YES	NO	Type of Cancer:			
ANXIETY□ **PANIC ATTACKS**□ **DEPRESSION**□ **PTSD**□ **BIPOLAR**□ **SCHIZOPHRENIA**□ **SUICIDE THOUGHTS**□						
ANY OTHER ILLNESS-						

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

WHO IS ANSWERING: _____ **RELATION TO THE PATIENT:** _____

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

DOCTORS' SAME DAY SURGERY CENTER

PRE-OPERATIVE EVALUATION

FOR ANESTHESIA PROVIDER ONLY:

SURGEON'S REQUEST - TYPE OF ANESTHESIA / NERVE BLOCK:			
CLEARANCE REQUESTED: YES☐ NO☐		**FROM:** PCP☐ CARDIOLOGY☐ PULMONARY☐ NEURO☐ OTHER SPECIALITY☐	
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:**