South Coast Anesthesia

PRE-ANESTHESIA EVALUATION

INSTRUCTIONS TO THE PATIENT - The intention of this questionnaire is to help your anesthetist select the appropriate anesthetic technique specific for you.

Name:					Today's Date:	
General Health	Excellent ☐	Good ☐	WEIGHT (lbs)	HEIGHT (in.)	AGE	GENDER
	Fair ☐	Poor ☐				

Has anyone in your family:			
	had a tendency to bleed excessively?	YES	NO
	had unexplained fevers during anesthesia?	YES	NO
	had any unusual reactions to anesthesia?	YES	NO

YES	NO	YOUR MEDICAL HISTORY	CHECK BOXES
		Do you smoke?	Have you had surgery on the…? Brain ☐ Neck ☐
		Do you drink alcoholic beverages?	Abdomen ☐ Lung ☐ Heart ☐
		Have you had a blood transfusion?	Thyroid ☐ Kidney ☐ Other:
		Are you pregnant at this time?	Jaw ☐ Breast ☐
		Are you allergic to any medications?	If yes, what?

YES	NO	HAVE YOU EVER HAD…	YES	NO	HAVE YOU EVER HAD…
		Heart disease, failure, or attack?			Thyroid disease?
		Heart murmer? Rheumatic fever?			Diabetes Mellitus?
		High blood pressure?			Frequent indegestion? Hiatal hernia?
		Palpitations (irregular heart beats)?			Ulcers? Obstructions?
		Chest pain or angina?			Easy bruising or excessive bleeding?
		Abnormal EKG?			Blood disorders?
		Stroke?			Glaucoma?
		Abnormal shortness of breath?			Frequent headaches?
		Asthma or wheezing?			Nerve paralysis?
		Emphysema?			Fainting spells?
		Bronchitis? Pneumonia?			Epilepsy (seizures)?
		Tuberculosis?			Back pain, problems, arthritis?
		Smoker"s cough?			Phlebitis?
		Hay fever?			Nervous or psychiatric disorder?
		Hepatitis? Liver disease?			Drug addiction or alcoholism?
		Gallbladder disease?			Serious illness during pregnancy?
		Kidney disease?			Motion sickness?
		Sickle cell anemia?			Other illness not mentioned?

YES	NO	DO YOU…	YES	NO	DO YOU…
		Wear removable dentures?			Have a false eye?
		Contact lenses?			Have any teeth loose or chipped?
		False eyelashes?			Have any major congenital defects?
		Have procelain caps on your teeth?			Have difficulty opening your mouth?
		Have difficulty w/ head movement?			Have cataracts?

YES	NO	WHAT KIND OF ANESTHESIA HAVE YOU HAD BEFORE?			
		Saddle/spinal "block"/epidural			Local or nerve blocks?
		General (completely asleep)			Have you had any unusual reactions, problems or complications with anesthesia?
		Pentothal?			

MEDICATIONS: **Please list names & doses of any medicines you take now or have taken within the last 6 months.**

Patient or Guardian Signature: