Anesthesiologists of Greater Orlando, Inc.

☐ BSSC ☐ FSC ☐ OCOS ☐ OOOSC ☐ SLSC

PATIENT LABEL

Pre-Anesthesia Assessment

Procedure:

Medical History (*Check all that apply*):

__ Stroke/TIA/Carotid Disease
__ Seizure Disorder
__ Headaches
__ Dizziness, Fainting
__ Parkinson's disease
__ Dementia / Alzheimer's
__ Depression
__ Anxiety or Panic Disorder
__ Paralysis or muscle weakness disorder
__ Numbness in face, arms, or leg
__ Muscular dystrophy, MS, Myasthenia

__ Diabetes
__ Insulin Pump
__ Thyroid Disorder
__ Steroid Medication past 3 months
__ Obesity (BMI>30)
__ Endocrine disorder

__ Alcohol consumption
__ Recreational drug use/abuse

__ Asthma/ Wheezing
__ Bronchitis/Emphysema/COPD
__ Shortness of breath
__ TB history
__ Respiratory Infection now or last 2 weeks
__ Sleep Apnea
__ Snoring
__ CPAP or BiPAP use
__ Oxygen therapy
__ Smoker, ___ packs per day x ____ yrs.

__ High Blood Pressure
__ Angina/Chest pain /Coronary artery disease
__ Palpitations/Irregular heartbeat
__ Congestive heart failure
__ Heart valve abnormality
__ Heart Attack
__ Cardiac surgery/ Stent/Angioplasty
__ Stress test/Catheterization/Echocardiogram
Date last performed ____________
__ Pacemaker/Defibrillator last checked _______

__ GERD/ Acid reflux
__ Hiatal hernia
__ GI Ulcer/ Bleed
__ Liver Disease/Cirrhosis/Hepatitis ___
__ Diarrhea

__ Kidney disease
__ Bladder/Urinary problems

__ Anemia/Sickle cell disease/blood disorder
__ Bruise easily/ Hemophilia/ bleeding disorder
__ Transfusion
__ HIV +

__ Glaucoma
__ Eye problems
__ Contact lenses

__ Arthritis
__ Joint replacement
__ Joint limitations

__ Chronic Pain
Where? ______________________
Baseline **Pain Score** _____ out of 10
__ Fibromyalgia
__ Pain from condition related to planned procedure
__ Regular narcotic use

__ Skin lesions/bruises/rashes
__ Body piercings
__ Hearing impairment
__ Limb prosthesis
__ Other Impairments/Disabilities:

__ Cancer:

__ Any possibility of pregnancy? _____
__ Last menstrual period ____/____/_____

__ Dentures/ Partials/ Bridges
__ Implants
__ Veneers/caps/crowns
__ Chipped teeth __ Loose teeth

__ Nausea/ Vomiting after anesthesia
__ Malignant Hyperthermia
__ Other anesthesia problems:

EXERCISE CAPACITY:

Surgical History (*list dates and procedures*)

Allergies (*medications, latex, food, etc.*)

Medications /Supplements/Herbals (*list dosage and frequency*) (*Garlic/Ginger/Gingko/Sweet Clover/St John's Wort, etc*)

Lab studies:

ECG:

Interviewer's Signature: **Date:** **Time:**

History & Physical: Age: ____ Height: ________ Weight: _____lbs BMI: _____ NPO@ _______ ASA ___

Exam:

Airway -

Mallampati I II III

Dental: ______________

Heart -

Lungs -

Type of anesthesia discussed with patient:

Risks, procedures, benefits, options of anesthesia discussed with patient or patient's representative who understands and accepts. All questions answered.

Anesthesiologist Signature: **Date:** **Time:**

Post-Anesthesia Note:

___ No anesthesia related complications
___ Vital signs in patient's normal range
___ Respiratory function stable, airway patent
___ Cardiovascular function and hydration status stable
___ Mental status recovered, patient participates in evaluation.
___ Pain control satisfactory
___ Nausea and vomiting control satisfactory

Anesthesiologist Signature:______________________ **Date:**____________ **Time:**________