

# Anesthesiologists of Greater Orlando

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## Pre-Anesthesia Assessment

Procedure:

### Medical History (Check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Stroke/TIA/Carotid Disease                | <input type="checkbox"/> High Blood Pressure                          | <input type="checkbox"/> Chronic Pain                                     |
| <input type="checkbox"/> Seizure Disorder                          | <input type="checkbox"/> Angina/Chest pain /Coronary artery disease   | Where? _____  |
| <input type="checkbox"/> Headaches                                 | <input type="checkbox"/> Palpitations/Irregular heartbeat             | Baseline <b>Pain Score</b> ____ out of 10                                 |
| <input type="checkbox"/> Dizziness, Fainting                       | <input type="checkbox"/> Congestive heart failure                     | <input type="checkbox"/> Fibromyalgia                                     |
| <input type="checkbox"/> Parkinson's disease                       | <input type="checkbox"/> Heart valve abnormality                      | <input type="checkbox"/> Pain from condition related to planned procedure |
| <input type="checkbox"/> Dementia / Alzheimer's                    | <input type="checkbox"/> Heart Attack                                 | <input type="checkbox"/> Regular narcotic use                             |
| <input type="checkbox"/> Depression                                | <input type="checkbox"/> Cardiac surgery/ Stent/Angioplasty           |   |
| <input type="checkbox"/> Anxiety or Panic Disorder                 | <input type="checkbox"/> Stress test/Catheterization/Echocardiogram   |   |
| <input type="checkbox"/> Paralysis or muscle weakness disorder     | Date last performed _____   |   |
| <input type="checkbox"/> Numbness in face, arms, or leg            | <input type="checkbox"/> Pacemaker/Defibrillator last checked _____   | <input type="checkbox"/> Skin lesions/bruises/rashes                      |
| <input type="checkbox"/> Muscular dystrophy, MS, Myasthenia        |   | <input type="checkbox"/> Body piercings                                   |
|  |   | <input type="checkbox"/> Hearing impairment                               |
| <input type="checkbox"/> Diabetes                                  | <input type="checkbox"/> GERD/ Acid reflux                            | <input type="checkbox"/> Limb prosthesis                                  |
| <input type="checkbox"/> Insulin Pump                              | <input type="checkbox"/> Hiatal hernia                                | <input type="checkbox"/> Other Impairments/Disabilities:                  |
| <input type="checkbox"/> Thyroid Disorder                          | <input type="checkbox"/> GI Ulcer/ Bleed                              |   |
| <input type="checkbox"/> Steroid Medication past 3 months          | <input type="checkbox"/> Liver Disease/Cirrhosis/Hepatitis ____       | <input type="checkbox"/> Cancer:  |
| <input type="checkbox"/> Obesity (BMI>30)                          | <input type="checkbox"/> Diarrhea                                     | <input type="checkbox"/> Any possibility of pregnancy? ____               |
| <input type="checkbox"/> Endocrine disorder                        | <input type="checkbox"/> Kidney disease                               | <input type="checkbox"/> Last menstrual period ____/____/____             |
|  | <input type="checkbox"/> Bladder/Urinary problems                     | <input type="checkbox"/> Dentures/ Partials/ Bridges                      |
| <input type="checkbox"/> Alcohol consumption                       | <input type="checkbox"/> Anemia/Sickle cell disease/blood disorder    | <input type="checkbox"/> Implants   |
| <input type="checkbox"/> Recreational drug use/abuse               | <input type="checkbox"/> Bruise easily/ Hemophilia/ bleeding disorder | <input type="checkbox"/> Veneers/caps/crowns                              |
|  | <input type="checkbox"/> Transfusion                                  | <input type="checkbox"/> Chipped teeth __ Loose teeth                     |
| <input type="checkbox"/> Asthma/ Wheezing                          | <input type="checkbox"/> HIV +  |   |
| <input type="checkbox"/> Bronchitis/Emphysema/COPD                 |   | <input type="checkbox"/> Nausea/ Vomiting after anesthesia                |
| <input type="checkbox"/> Shortness of breath                       | <input type="checkbox"/> Glaucoma                                     | <input type="checkbox"/> Malignant Hyperthermia                           |
| <input type="checkbox"/> TB history                                | <input type="checkbox"/> Eye problems                                 | <input type="checkbox"/> Other anesthesia problems:                       |
| <input type="checkbox"/> Respiratory Infection now or last 2 weeks | <input type="checkbox"/> Contact lenses                               |   |
| <input type="checkbox"/> Sleep Apnea                               |   | <b>EXERCISE CAPACITY:</b>   |
| <input type="checkbox"/> Snoring                                   | <input type="checkbox"/> Arthritis                                    |   |
| <input type="checkbox"/> CPAP or BiPAP use                         | <input type="checkbox"/> Joint replacement                            |   |
| <input type="checkbox"/> Oxygen therapy                            | <input type="checkbox"/> Joint limitations                            |   |
| <input type="checkbox"/> Smoker, ____ packs per day x ____ yrs.    |   |   |

### Surgical History (list dates and procedures)

Allergies (medications, latex, food, etc.)

### Medications /Supplements/Herbals (list dosage and frequency) (Garlic/Ginger/Ginkgo/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 -**

**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:

- |   |   |
|---|---|
| <input type="checkbox"/> No anesthesia related complications        | <input type="checkbox"/> Cardiovascular function and hydration status stable          |
| <input type="checkbox"/> Vital signs in patient's normal range      | <input type="checkbox"/> Mental status recovered, patient participates in evaluation. |
| <input type="checkbox"/> Respiratory function stable, airway patent | <input type="checkbox"/> Pain control satisfactory                                    |
|   | <input type="checkbox"/> Nausea and vomiting control satisfactory                     |

Anesthesiologist Signature:

Date:

Time: