



# ORLANDO HEALTH

1414 Kuhl Ave. • Orlando, FL 32806

## ANESTHESIOLOGISTS OF GREATER ORLANDO PREANESTHESIA ASSESSMENT

LINE UP PATIENT I.D. LABEL HERE

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

**Medical History** (Check all that apply and circle item within checked category as applicable)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Stroke/ TIA/ Carotid Disease              | <input type="checkbox"/> High Blood Pressure                          | <input type="checkbox"/> Arthritis                             |
| <input type="checkbox"/> Seizure disorder/ Epilepsy                | <input type="checkbox"/> Angina/ Chest Pain/ Coronary disease         | <input type="checkbox"/> Joint limitations                     |
| <input type="checkbox"/> Headache/ Migraines                       | <input type="checkbox"/> Palpitations/ Irregular heartbeat            | <input type="checkbox"/> Joint Replacement                     |
| <input type="checkbox"/> Dizziness/ Fainting                       | <input type="checkbox"/> Congestive Heart Failure                     | <input type="checkbox"/> Chronic Pain                          |
| <input type="checkbox"/> Parkinson's Disease                       | <input type="checkbox"/> Cardiomyopathy                               | Pain Score ___ out of 10 baseline                              |
| <input type="checkbox"/> Dementia/ Alzheimer's                     | <input type="checkbox"/> Heart murmur, valve abnormality              | <input type="checkbox"/> Fibromyalgia                          |
| <input type="checkbox"/> Depression                                | <input type="checkbox"/> Heart surgery / Stent/ Angioplasty           | <input type="checkbox"/> Regular Narcotic Use                  |
| <input type="checkbox"/> Anxiety/ Panic Disorder                   | <input type="checkbox"/> Heart attack (MI), when? _____               | <input type="checkbox"/> Skin lesions/ bruises/ rashes         |
| <input type="checkbox"/> Muscle weakness/ Paralysis                | <input type="checkbox"/> Pacemaker / Defibrillator last checked _____ | <input type="checkbox"/> Body piercings, Where?                |
| <input type="checkbox"/> Numbness in face, arms, legs              | Manufacturer? _____   | <input type="checkbox"/> Limb prosthesis                       |
| <input type="checkbox"/> Muscular dystrophy, MS, Myasthenia        | <input type="checkbox"/> Stress test/ Catheterization/ Echocardiogram | <input type="checkbox"/> Other impairments or disabilities:    |
| <input type="checkbox"/> Spina Bifida                              | Last date performed _____   |  |
|  | Cardiologist _____  |  |
| <input type="checkbox"/> Diabetes Type I / Type II                 | <input type="checkbox"/> GERD / Acid reflux                           | <input type="checkbox"/> Glaucoma                              |
| <input type="checkbox"/> Insulin Pump                              | <input type="checkbox"/> Hiatal hernia                                | <input type="checkbox"/> Eye problems                          |
| <input type="checkbox"/> Thyroid disorder                          | <input type="checkbox"/> Difficulty swallowing                        | <input type="checkbox"/> Contact lenses                        |
| <input type="checkbox"/> Steroid Medication past 3 months          | <input type="checkbox"/> GI Ulcer/ Bleeding                           | <input type="checkbox"/> Cancer/ Tumor                         |
| <input type="checkbox"/> Obesity                                   | <input type="checkbox"/> Liver disease/ Cirrhosis                     |  |
| <input type="checkbox"/> Endocrine Disorder                        | <input type="checkbox"/> Diarrhea                                     | <input type="checkbox"/> Any possibility of pregnancy? _____   |
| <input type="checkbox"/> Asthma/ Wheezing                          | <input type="checkbox"/> Hepatitis type _____                         | Last menstrual period ___/___/___                              |
| <input type="checkbox"/> Bronchitis/ Emphysema/ COPD               |   |  |
| <input type="checkbox"/> Shortness of breath                       | <input type="checkbox"/> Kidney disease                               | <input type="checkbox"/> Dentures/ Implants/ Partials/ Bridges |
| <input type="checkbox"/> TB history                                | <input type="checkbox"/> Bladder/ Urinary problems                    | <input type="checkbox"/> Veneers / Caps / Crowns               |
| <input type="checkbox"/> Respiratory Infection now or last 2 weeks |   | <input type="checkbox"/> Chipped teeth / Loose teeth           |
| <input type="checkbox"/> Sleep Apnea / Snoring                     | <input type="checkbox"/> Anemia/ Sickle Cell/ Blood disorder          | <input type="checkbox"/> Recreational drug use / abuse         |
| <input type="checkbox"/> CPAP or BiPAP use                         | <input type="checkbox"/> Bruise easily/ Hemophilia/ Bleeding disorder | <input type="checkbox"/> Alcohol ___ drinks per day avg.       |
| <input type="checkbox"/> Oxygen therapy                            | <input type="checkbox"/> Previous transfusion                         |  |
| <input type="checkbox"/> Smoker ___ packs per day ___ years        | <input type="checkbox"/> HIV +  |  |

**Additional Medical History / Comments:**

- Exercise capacity:**  Minimal to no activity  
 Can walk 1-2 blocks on level ground, walk inside house, light housework. (1Met)  
 Can climb flight of stairs, run short distances, heavy housework like scrubbing floors. (4 Mets)  
 Can participate in strenuous sports such as swimming, basketball, football, singles tennis. (10 Mets)

**Surgical History and Major Hospitalizations:** (list dates and procedures requiring anesthesia)

- Anesthesia History:**  History of Malignant Hyperthermia in you or family members, or history of high fever after surgery.  
 Pseudocholinesterase deficiency, succinylcholine allergy.  
 Previous difficulty with airway, problems with intubation, severe sore throat after anesthesia or TMJ.  
 History of motion sickness or nausea/vomiting after anesthesia.

**Medications/Supplements/Herbals:** (list dose and frequency, include herbals such as Garlic, Gingko, Sweet clover, St. John's wort, etc)

**Allergies:** (medications, latex, food, etc.) **List adverse reaction for each allergen listed**

Patient Signature/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_