

Nacogdoches Surgery Center

Patient Label here

Anesthesia Evaluation Report

Age:			Actual		Stated
Height:			Actual		Stated
Weight:			Actual		Stated

HAVE YOU HAD:	Yes	No	
Heart Trouble/Chest pains			
High Blood Pressure			
Lung Disease/Difficulty Breathing/Productive Cough			
Epilepsy or Seizures			
Jaundice			
Hepatitis or Mononucleosis			
PUD / Hiatal Hernia / GERD			
Back Trouble			
Glaucoma			
Abnormal Bleeding Tendencies			
Anticoagulant Therapy (blood thinners)			
Blood Disease (anemia, etc.)			
Kidney Disease/Difficulty with Urination			
Fracture of Facial Bones			
Fracture of Neck or Back			
Muscle Weakness			
Paralysis/Numbness/Tingling			
Blood Transfusion			
Stroke			
Blood Vessel Disease (phlebitis, etc)			
Diabetes			
Arthritis			
Chest X-ray in past year			
Electrocardiogram in past year			
Medical Illnesses (please list)			
Do You: (✓ if brought to center)	✓	Yes	No
Wear Dentures			
Have Loose Teeth/Caps/Bridges			
Wear Glasses/Contacts			
Wear Prosthesis			
Wear Hearing Aid			
Do You Smoke? Pkg/Day			
Have You Ever Smoked?			
Use Alcohol? (Amt/Day)			
Females: Could You Be Pregnant?			
Religious Objection to Blood Transfusion?			
Explain:			

Allergies to Drugs or Medicines	
Medication/Drug	Reaction

PREVIOUS ANESTHETIC HISTORY	
Date of last anesthetic: _____	
Any abnormal reactions: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____	
Relatives with abnormal reactions to anesthetics: <input type="checkbox"/> Yes <input type="checkbox"/> No	
COMMENTS: _____	
Do you have any questions for your anesthesiology provider? _____	

Previous Surgeries	
Surgery	Date

Medication You Are Currently Taking		
Drug	Frequency	Last Taken

When did you last eat or drink? _____
Date Time

Patient's Signature: _____
Signature when above information completed by Patient

Physical Examination

PRE-ANESTHESIA EVALUATION:
General Appearance: _____
Sensorium: _____
Head & Neck: _____
Cardiovascular: _____
Chest: _____
Abdomen: _____
Extremities: _____
Skin: _____
Risk: ASA 1 2 3 4 5 E
Anesthetic Proposed: <input type="checkbox"/> Local <input type="checkbox"/> MAC/TIVA
<input type="checkbox"/> General <input type="checkbox"/> Spinal <input type="checkbox"/> Standby <input type="checkbox"/> Regional
I have explained Anesthesia risks, benefits and alternatives to care..... <input type="checkbox"/>
Anesthesiology Provider Date

POST-ANESTHESIA EVALUATION
Condition: _____

Complications: _____

Comments: _____

Anesthesiology Provider Date