Pre-Anesthetic Medical Evaluation

This form must be completed prior to surgery. Please present this questionnaire to the Anesthesia Provider who visits you to discuss your anesthetic prior to your procedure. THANK YOU. DEPARTMENT OF ANESTHESIOLOGY.

DATE: _____

PLEASE PRINT

NAME:_____ **AGE:**_____ **SEX:** _____ **HT:**_____ **WT.**_____

Chief Complaint / Present Problem: _____

_____

Proposed Surgery:_____ Surgeon:_____

PAST MEDICAL HISTORY

Drug Allergies: _____

Medicines Taken Regularly: _____

_____

Have you taken steroids (Cortisone, Hydrocortisone, Prednisone, or Decadron) within the past 12 months? NO_____ YES_____

List all previous operations:_____

_____

Approximate Date of Last Anesthetic:

Was this or any previous anesthetic done at Alabama Colon and Rectal Institute, P.C.?

NO_____ YES_____

Have you had any problems with anesthesia? NO_____ YES_____

Have any blood relatives had a serious problem with anesthesia? NO_____ YES_____

REVIEW OF SYSTEMS

Do you have a history of the following medical problems:

NO	YES	
_____	_____	Facial Plastic/Reconstructive Surgery
_____	_____	Jaw Clicking, pain or stiffness
_____	_____	Eye Diseases
_____	_____	Thyroid Disease / Goiter
_____	_____	Limited Neck Motion or Pain
_____	_____	Asthma
_____	_____	Bronchitis / Emphysema / Other Lung Disorder
_____	_____	High Blood Pressure
_____	_____	Chest Pain or Shortness of Breath
_____	_____	Heart Attack / Other Heart Disease
_____	_____	Hepatitis, Jaundice or Liver Disease
_____	_____	Kidney Disease
_____	_____	Diabetes Mellitus
_____	_____	Anemia / Free Bleeding / Blood Disease
_____	_____	Epilepsy or Seizures
_____	_____	Stroke / Other Neurologic Disorder
_____	_____	Back Problems / Limited Joint Movement
_____	_____	Other

PLEASE FILL OUT, SIGN & RETURN DAY OF PROCEDURE.

Do you frequently awaken with numbness in arm or leg? No___ Yes ___

Are you pregnant? N/A ___ Not Sure ___ No ___ Yes ___ Date of last menstrual period?_____

Are you right handed? ___ Left handed? ___

Do you wear contact lenses? No ___ Yes ___

Do you have the following? and Describe Where):

CAPPED TEETH / CROWNS _____ BRIDGES: (Permanent)_____

LOOSE TEETH _____ BRIDGES: (Temporary) _____

DENTURES / OTHER REMOVABLE DENTAL APPLIANCES:_____

DATE: _____

SOCIAL HISTORY

Occupation_____ What type of exercise do you get_____

_____

Are you a smoker? No ___ Yes ___ Packs per day _____ How long?_____

Quit when? _____ What is your alcohol consumption? _____

Do you have a religious contraindication to blood transfusion? No ___ Yes ___

SIGNATURE OF PATIENT, RELATIVE OR GUARDIAN? _____