PRE-ANESTHESIA EVALUATION

WILLAMETTE SURGERY CENTER

Current Height:_____ Current Weight:_____

Mark YES or NO for EACH ITEM LISTED:

Y N Cardiovascular
- ☐ ☐ Heart Attack
  *Date:*_____
- ☐ ☐ Stent
  Type:_____
  *Date:*_____
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Chest Pain
  *Date:*_____
- ☐ ☐ Arrhythmias or Palpitations
- ☐ ☐ Heart Failure
- ☐ ☐ Pacemaker / Defibrillator
  *Date:*_____
- ☐ ☐ Heart Surgery
  *Date:*_____
- ☐ ☐ Shortness of Breath
- ☐ ☐ Valve Disease / Heart Murmur
- ☐ ☐ Do you need antibiotics for dental work?
- ☐ ☐ Do you or your family have a history of blackouts or fainting?
- ☐ Other:_____

Y N Neurological
- ☐ ☐ Seizures
- ☐ ☐ Stroke
  *Date:*_____
- ☐ ☐ Mini-Stroke / TIA
  *Date:*_____
- ☐ ☐ Muscle Disease
  Type:_____
- ☐ ☐ Back / Neck Pain
- ☐ ☐ Back / Neck Surgery
  *Date:*_____
- ☐ ☐ Spinal Stimulator
- ☐ ☐ Depression / Mental Health Issues
- ☐ Other:_____

Y N Blood
- ☐ ☐ Sickle Cell Anemia
- ☐ ☐ Clotting / Bleeding Problems
- ☐ ☐ History of Blood Clots
  *Date:*_____
- ☐ Other:_____

Y N Kidney
- ☐ ☐ Kidney / Bladder Problems
- ☐ ☐ Kidney Surgery
  *Date:*_____

Y N Respiratory
- ☐ ☐ Asthma
- ☐ ☐ Emphysema / COPD
- ☐ ☐ Bronchitis / Chronic Cough
- ☐ ☐ Recent Respiratory Infection
- ☐ ☐ Sleep Apnea
- ☐ ☐ Use CPAP
- ☐ ☐ Lung Surgery
  *Date:*_____
- ☐ Other:_____

Y N Endocrine
- ☐ ☐ Diabetes *(high blood sugar)*
  ☐ Type I ☐ Type II ☐ Prediabetic
- ☐ ☐ Thyroid Problems
- ☐ ☐ Thyroid Surgery
- ☐ Other:_____

Y N Infectious
- ☐ ☐ MRSA / VRE
  *Date:*_____
- ☐ Other:_____

Y N Gastrointestinal
- ☐ ☐ Acid Reflux / Heartburn
- ☐ ☐ Hiatal Hernia
  Fixed:_____
- ☐ Other:_____

Y N Other
- ☐ ☐ Cancer
  Type:_____
- ☐ ☐ Hepatitis
  Type:_____
  *Date:*_____
- ☐ ☐ Liver Disease
  *Date:*_____
- ☐ Other:_____

Y N Social History
- ☐ ☐ Recreational Drugs
  Type:_____
  Last Use:_____
- ☐ ☐ Alcohol
  Type:_____
  Amount:_____
- ☐ ☐ Tobacco *(current or former)*
  Type:_____
  Amount:_____
  Quit:_____
  *Date:*_____

Y N Anesthesia Problems
- ☐ ☐ Difficulty Opening Jaw
- ☐ ☐ Difficult Intubation
- ☐ ☐ History of *(you or family members):*
- ☐ ☐ Anesthesia Problems
- ☐ ☐ Malignant Hyperthermia
- ☐ Other:_____

Y N Teeth
- ☐ ☐ Missing / Loose / Chipped Tooth
- ☐ ☐ Dentures / Partials
- ☐ ☐ Fixed Bridge

Y N Females
- ☐ ☐ Possibility of Pregnancy
- ☐ ☐ Breast Feeding

Do you have an **ADVANCED DIRECTIVE?** ☐ **Yes** ☐ **No**

Do you have any **SPECIAL LEARNING NEEDS?** _____

Do you have any **OTHER SPECIAL NEEDS?** _____

Do you have a **RELIGIOUS PREFERENCE?** _____

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge. I am aware that my answers could affect my healthcare or that of the patient for whom I am responsible.

SIGNATURE OF PATIENT/PARENT/GUARDIAN: _____

Date: _____

PLEASE COMPLETE BACK PAGE

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WILLAMETTE SURGERY CENTER

Are you allergic to **LATEX?** *(Please check and notify the nurse on admission)* ☐ YES ☐ NO

List other **ALLERGIES:**	**REACTIONS:**	List **SURGERIES** not mentioned on other side:
☐ *Check this box if you do NOT have any allergies.*		☐ *Check this box if you have never had surgery.*

Below **PRINT** all the **MEDICATION** you take, including over-the-counter, vitamins, and herbal supplements.

☐ *Check this box if you do NOT take any medications.* ☐ *Check this box if you attached a separate medication list.*

Name of Medication	**Dose**	**How taken?** *(by mouth, etc.)*	**How often?**	**Reason for taking**

DO NOT WRITE IN THIS BOX

Prescribed Postop Medication	Dosage	Frequency & Route	Reason for Taking	Time Last Dose Taken at WSC
		By mouth every ____ hrs as needed		
		By mouth every ____ hrs as needed		
		By mouth every ____ hrs as needed		
		By mouth every ____ hrs as needed		

IN THE EVENT OF ANY MEDICAL EMERGENCY OR FOLLOW-UP CARE, PLEASE PROVIDE THIS MEDICATION LIST