SPECIALTY ORTHOPAEDICS SURGERY CENTER, LLC

PRE-ANESTHESIA QUESTIONNAIRE/EVALUATION

Print Patient Name:_____ Procedure/Site Validation_____ Date/Initial_____

I. SURGERIES (List all operations):_____

_____

_____

Do you have any MEDICATION ALLERGIES? Yes No
If "YES," please list:_____
Reactions:_____

_____

Do you have any FOOD ALLERGIES? Yes No
If "YES," please list:_____
Are you allergic to LATEX or RUBBER PRODUCTS? Yes No
Reaction:_____
Adhesive Tape/Bandaids? Yes No

II. DRUGS AND MEDICATIONS:
List all medication you take on page 2 attached
(including herbal supplements, diet pills/recreational drugs and vitamins):

III. Primary Care Physician:_____ Phone:_____
Specialty Physician:_____ Phone:_____

IV. AGE:_____ HEIGHT:_____ WEIGHT:_____ lbs. _____ kg.

V. HAVE YOU HAD:

1.	High Blood Pressure	Yes	No_____
2.	Heart trouble or Heart Attack	Yes	No_____
3.	Chest Pain or Angina	Yes	No_____
	a) Irregular Heart Beat	Yes	No_____
	b) Congestive Heart Failure	Yes	No_____
	c) Abnormal electrocardiogram (EKG)	Yes	No_____
4.	Gastric Reflux, Hiatal Hernia, Ulcers	Yes	No_____
5.	Pulmonary Disease, Asthma, Emphysema	Yes	No_____
6.	Sleep Apnea	Yes	No_____
7.	Diabetes (insulin or oral meds?)	Yes	No_____
8.	Yellow Jaundice or Hepatitis	Yes	No_____
9.	Kidney Disease	Yes	No_____
10.	Thyroid Disease	Yes	No_____
11.	Abnormal bleeding problems	Yes	No_____
12.	Stroke, numbness, or weakness	Yes	No_____
13.	Epilepsy or convulsive seizures	Yes	No_____
14.	Have you or any blood relative ever had a problem with anesthesia?	Yes	No_____
15.	Any contagious disease(s) including HIV, history of MRSA, etc.	Yes	No_____
16.	Psychological or emotional problems	Yes	No_____
17.	Any problems with motion sickness	Yes	No_____
18.	Body piercing/metal in body	Yes	No_____
19.	Arthritis, Rheumatoid Arthritis, or history of difficult intubation	Yes	No_____
20.	Other	Yes	No_____
21.	Family History	Yes	No_____

VI. DO YOU:

1.	Wear Dentures or Partials/Crowns or have loose teeth	Yes	No_____
2.	Drink alcohol (How much per day?)	Yes	No_____
3.	Smoke (How much per day?)	Yes	No_____
4.	Have legal guardianship/POA/Living Will	Yes	No_____

Phone number you can be reached at before surgery: ( ) _____
Signed by Patient: _____ Date: _____
Questionnaire and Pre-op teaching done by _____ Date: _____

PATIENTS DO NOT FILL OUT THIS SECTION:

Time of last PO intake: solids_____ liquids_____

Pregnancy Test DOS: ( ) Neg ( ) Post-hysterectomy ( ) Post-menopausal

Gen/psycho-social:_____ A/W:_____
CV:_____ EKG:_____
Lungs:_____

Plan: Gen MAC IV Regional Regional Block **Discussed with patient/responsible adult who agrees**
ASA Class: I II III

Anesthesiologist:_____
Date:_____ Time:_____

PE (Day of Surgery): VS: BP____ P____ R____ O2Sat (Room Air)____

Lab results reviewed:_____ BS_____
Patient acceptable for surgery:_____
(If not, see Progress Notes for explanation)

Pt. ID