HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

HC10015-1

PRE-ANESTHESIA ASSESSMENT FORM

Please call 410-884-4693 for questions regarding this form.

Procedure:_____ ☐**Left** ☐**Right**

Name you would preferred to be called:_____

Age_____**Height**_____**Weight**_____ **BMI**_____**Date of Surgery**_____

List of all previous surgeries:	Medications (prescribed medications, over the counter medications):	Food and drug allergies/reactions:
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____	_____
_____	☐ Taking Beta blockers Premed:_____	_____
	☐ Taking Blood thinners Time:_____	☐ Latex allergy

Check	Do you now have or have you ever had a history of:
	Cardiovascular Disease
☐	Chest Pain/Tightness/Pressure/ Heart Attack
☐	Irregular Heart Beat
☐	Pacemaker/Defibrillator Brand:_____
☐	Problem with circulation
☐	Blood clot in legs or lungs
☐	High blood pressure
☐	Other_____
	Respiratory Disease
☐	Smoking_____packs per day; Quit_____
☐	Asthma
☐	Emphysema/bronchitis
☐	Shortness of breath at rest
☐	Upper respiratory infection (cold) within 2 weeks
☐	Sleep apnea ☐ Use CPAP
	Neurological Disorder
☐	Stroke or mini-stroke (T.I.A.)
☐	Seizures
☐	Back or neck problems
☐	Physical restrictions/limitations
☐	Forgetfulness, memory loss, confusion
☐	Multiple sclerosis/muscular dystrophy
☐	Nerve/spinal cord injury
☐	Neuropathy
☐	**Diabetes** . ☐ Taking insulin ☐ Insulin pump
☐	**Thyroid Problem**
☐	**Kidney/Bladder/Prostate Disorder**
	If yes, specify _____
☐	Inability to urinate after anesthesia
☐	Dialysis : Schedule_____
	Gastro-Intestinal Disease
☐	Liver disease (jaundice, hepatitis)
☐	Hiatal hernia/reflux/heartburn
☐	Other _____

Check	Do you now have or have you ever had a history of:
	Blood Disorder
☐	Abnormal bleeding tendency or taking blood thinners
☐	Sickle cell disease or trait
☐	History of blood transfusions .
☐	Religious or other objections to blood transfusion
☐	HIV positive/AIDS
☐	**Eye Disorder/Glaucoma/Retinal detachment**
☐	**Ear Disorder/"Ringing" in ears/Hearing loss**
☐	**Cancer/chemotherapy/radiation therapy**
	If yes, specify _____
☐	**Psychiatric disorder**
	If yes, specify _____
☐	**Other illness or disease**
	If yes, specify_____
	For women
☐	Could you be pregnant?
	First day of last menses _____
☐	Post menopause/hysterectomy
	Anesthesia Related Information
☐	Anesthesia within one year
☐	History of difficult intubation
☐	Any objection to spinal/epidural anesthesia
☐	Adverse reaction to anesthesia
☐	Relative with Malignant Hyperthermia
☐	Nausea or vomiting after anesthesia
☐	Are you aware of the risk of eating or drinking the day of your anesthesia
	Because drugs may interact adversely with anesthesia, please indicate the following:
☐	History of regular alcohol use or within 24 hours
☐	Use of steroids/cortisone in the past year
☐	History of "street drugs" use or within 30 days
☐	**Loose or capped teeth or dentures in place**

If form completed by patient: Date_____ **Time**_____ **Patient Signature**_____

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PRE-ANESTHESIA ASSESSMENT FORM

To be completed by staff only

NPO_____

T_____BP_____

P_____R_____O_2 Sat_____

FBS _____@_____

WBC	Hct	Plts

Na	Cl	Glucose	BUN
K	CO2		Cr

INR	PT	PTT

UPT/SPT: ☐ Neg ☐ Pos Date_____

LFT's:_____ Ca:_____

CXR _____

_____Date_____

EKG_____

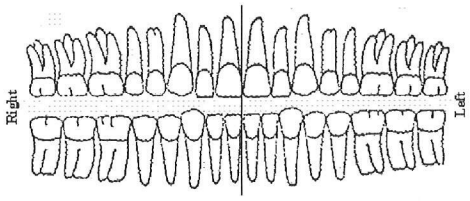
_____Date_____

Echo_____

_____Date _____

Stress Test_____

_____Date_____



PHYSICIAN ONLY

The risks, benefits, and alternatives of GA, Reg. and Loc/Sed have been discussed.

The plan is: ☐ GA ☐ Regional ☐ IV Sedation ☐ TIVA ☐ MAC

and/or _____

Date_____ Time_____ Signature _____

Physician/CRNA

☐ H&P reviewed, patient assessed; fit for planned anesthesia.

Intubation Assessment
I_____ II_____ III_____ IV_____

☐ Dentures ☐ Caps/Crowns
☐ Overbite ☐ Loose teeth

ROM: ☐ Full ☐ Limited ☐ None

☐ Lungs: clear to auscultation OR

_____

☐ Heart: regular rhythm with no murmurs OR

_____

ASA 1 2 3 4 5 6 E