



A Sutter Health Affiliate

PATIENT LABEL

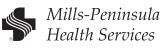
Legal name	
Go by name	
Date of birth	

ANESTHESIA PRE-OPERATIVE EVALUATION

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Height ft in Weight _	lb kg	ALL SURGERIES, most rec	ent first Year		
ALLERGIES (medication and food)					
Latex allergy: No reaction Yes		Problem(s) with anesthes	ia? 🗌 No 🔲 Yes		
Has a BLOOD RELATIVE ever had a probleeding, or muscular disease?					
Have you had a MAJOR ILLNESS or HOSP	ITALIZATION except fo	or surgery? 🗌 Yes 🔲 No_			
HIGH or LOW BLOOD PRESSURE? (circ	cle one if yes)	Yes No	/P		
HEART TROUBLE?		Yes No	(For physician and nurse only)		
\square angina/chest pain \square coronary art	ery disease 🗌 ang	jioplasty/stent			
☐ heart attack ☐ congestive heart f					
mitral valve prolapse murmur	☐ rneumatic fever				
pacemaker/defibrillator (ICD)	Loot ove	duction			
Manufacturer/model LUNG or BREATHING problem?					
□ asthma □ emphysema □ bronchitis □ sleep apnea □ use CPAP □ chronic cough □ shortness of breath □ nosebleeds □ nasal obstruction					
croup tuberculosis					
DIGESTIVE problem?		□ Yes □ No			
□ heartburn/reflux/hiatal hernia □ post-op nausea and vomiting					
☐ motion sickness ☐ gastric bypass	s/band 🗌 liver dise	ease/cirrhosis/hepatitis			
ulcer other					
ENDOCRINE problem?		Yes No			
Diabetes mellitus 🗌 Type 1 🔲 Type :	$2 \square$ thyroid othe	r			
VASCULAR disease?		Yes No			
☐ circulatory problem ☐ blood clots	•	tid disease			
taking blood thinners/anticoagulation	n				
KIDNEY FAILURE or DIALYSIS?					
Dialysis schedule					
NEUROLOGIC problem?					
epilepsy/seizure fainting/dizzi			Date Time		
depression/anxiety migraine/h		e/TIA/mini strokes	Cianalius		
□ numbness/weakness/neuropathy/nerve pain □ dementia			Signature		

SURGERY



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JOINT, NECK or BACK	problem?		🗌 Yes	□No
\square arthritis \square back $ $	pain/sciatica 🗆] jaw or TMJ limitation $\ \ \square$ neck pain or stiffness $\ \ \square$ so	coliosis	
TUMOR, LEUKEMIA or	CANCER ?		🗌 Yes	\square No
\square radiation therapy	Site	chemothe	erapy	
BLOOD concerns?			🗌 Yes	\square No
□ anemia □ HIV/AI	DS 🗌 Jehovah'	's Witness		
□ sickle cell disease/t	rait 🗌 prolonge	ed bleeding/easy bruising		
Donated blood for this	procedure?		🗌 Yes	□ No
RECENT EXPOSURE to chickenpox, measles, mumps, TB, or HIV?				\square No
FLU, FEVER, COLD or I	FLU, FEVER, COLD or RESPIRATORY INFECTION in the last two weeks?			
Taken CORTISONE or F	PREDNISONE in th	ne last year?	🗌 Yes	\square No
If yes, why?				
Do you have bridges, (dentures, caps, re	etainers, implants, braces, veneers, loose, chipped,		
or missing teeth ? <i>(cire</i>	cle all that apply)		🗌 Yes	☐ No
For women, could you be PREGNANT?				□ No
Would you like a pregn	ancy test? — Ye	es 🗌 No Last menstrual period		
It is important to disc	uss any drug use	e with the Anesthesiologist.		
Have you ever had a pr	oblem with ALCO	HOL or DRUGS?	🗌 Yes	\square No
Number of ALCOHOLIC	BEVERAGES you	ı drink per week?		
RECREATIONAL DRUG	S? Never	☐ Past ☐ Current Type and how much?		
Ever smoked CIGARETTES ? Never Past Current If so, how many packs/day # yrs				
Exposure to second-ha	and smoke?		🗌 Yes	\square No
BLOOD TESTS within t	he past month?	Yes No Where		
EKG in the last 6 month	าร?	Yes No Where		
Have you been experie	ncing pain at hom	ne? Yes No Where		
Do you have pain now?	·	Yes No Where		
Severity (circle one) N	lo pain 0 1 2 3 4	4 5 6 7 8 9 10 Most severe When?		
Medication you take fo	r pain	How often?		
PHONE number where	you can be reache	ed: before surgery after surgery		
Date	Time	Patient signature		
Date	Time	Personal representative signature		
		Relationship		
Date	Time	Nurse signature		
		M.D.		
Date	Time	Signature	ID#	

