Mills-Peninsula Health Services

A Sutter Health Affiliate

SURGERY

PATIENT LABEL

Legal name _____

Go by name _____

Date of birth _____

ANESTHESIA PRE-OPERATIVE EVALUATION

Height _____ **ft** _____ **in** **Weight** _____ **lb** _____ **kg**		**ALL SURGERIES, most recent first**	**Year**
ALLERGIES (medication and food)	**Type of reaction**		

Latex allergy: ☐ **No reaction** ☐ **Yes**_____

_____

Problem(s) with anesthesia? ☐ **No** ☐ **Yes**_____

_____

Has a **BLOOD RELATIVE** ever had a problem with **anesthesia**, **bleeding**, or **muscular disease**? ..... ☐ Yes ☐ No_____

Have **you** had a **MAJOR ILLNESS** or **HOSPITALIZATION except** for surgery?.... ☐ Yes ☐ No_____

HIGH or **LOW BLOOD PRESSURE**? *(circle one if yes)* ..... ☐ Yes ☐ No

HEART TROUBLE?..... ☐ Yes ☐ No

☐ angina/chest pain ☐ coronary artery disease ☐ angioplasty/stent

☐ heart attack ☐ congestive heart failure ☐ irregular heart beats

☐ mitral valve prolapse ☐ murmur ☐ rheumatic fever

☐ pacemaker/defibrillator (ICD)

Manufacturer/model _____ Last evaluation_____

LUNG or **BREATHING** problem? ..... ☐ Yes ☐ No

☐ 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/band ☐ liver disease/cirrhosis/hepatitis

☐ ulcer other _____

ENDOCRINE problem?..... ☐ Yes ☐ No

Diabetes mellitus ☐ Type 1 ☐ Type 2 ☐ thyroid other _____

VASCULAR disease? ..... ☐ Yes ☐ No

☐ circulatory problem ☐ blood clots/phlebitis ☐ carotid disease

☐ taking blood thinners/anticoagulation

KIDNEY FAILURE or **DIALYSIS**?..... ☐ Yes ☐ No

Dialysis schedule _____

NEUROLOGIC problem?..... ☐ Yes ☐ No

☐ epilepsy/seizure ☐ fainting/dizziness ☐ loss of vision ☐ Parkinson's

☐ depression/anxiety ☐ migraine/headache ☐ stroke/TIA/mini strokes

☐ numbness/weakness/neuropathy/nerve pain ☐ dementia

(For physician and nurse only)

_____ _____

Date Time

_____

Signature

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JOINT, NECK or **BACK** problem? ☐ Yes ☐ No

☐ arthritis ☐ back pain/sciatica ☐ jaw or TMJ limitation ☐ neck pain or stiffness ☐ scoliosis

TUMOR, LEUKEMIA or **CANCER**? ☐ Yes ☐ No

☐ radiation therapy Site _____ ☐ chemotherapy

BLOOD concerns? ☐ Yes ☐ No

☐ anemia ☐ HIV/AIDS ☐ Jehovah's Witness ☐ previous transfusion

☐ sickle cell disease/trait ☐ prolonged bleeding/easy bruising

Donated blood for this procedure? ☐ Yes ☐ No

RECENT EXPOSURE to chickenpox, measles, mumps, TB, or HIV? ☐ Yes ☐ No

FLU, FEVER, COLD or **RESPIRATORY INFECTION** in the last two weeks? ☐ Yes ☐ No

Taken **CORTISONE** or **PREDNISONE** in the last year? ☐ Yes ☐ No

If yes, why? _____

Do you have **bridges, dentures, caps, retainers, implants, braces, veneers, loose, chipped,** or **missing teeth**? *(circle all that apply)* ☐ Yes ☐ No

For **women**, could you be **PREGNANT**? ☐ Yes ☐ No

Would you like a pregnancy test? ☐ Yes ☐ No Last menstrual period _____

It is important to discuss any drug use with the Anesthesiologist.

Have you ever had a problem with **ALCOHOL** or **DRUGS**? ☐ Yes ☐ No

Number of **ALCOHOLIC BEVERAGES** you drink per week? _____

RECREATIONAL DRUGS? ☐ Never ☐ Past ☐ Current Type and how much? _____

Ever smoked **CIGARETTES**? ☐ Never ☐ Past ☐ Current If so, how many packs/day _____ # yrs. _____

Exposure to **second-hand smoke**? ☐ Yes ☐ No

BLOOD TESTS within the past month? ☐ Yes ☐ No Where _____

EKG in the last 6 months? ☐ Yes ☐ No Where _____

Have you been experiencing **pain** at home? ☐ Yes ☐ No Where _____

Do you have pain now? ☐ Yes ☐ No Where _____

Severity *(circle one)* No pain 0 1 2 3 4 5 6 7 8 9 10 Most severe When? _____

Medication you take for pain _____ How often? _____

PHONE number where you can be reached: before surgery _____ after surgery _____

Date _____ Time _____ Patient signature _____

Date _____ Time _____ Personal representative signature _____

Relationship _____

Date _____ Time _____ Nurse signature _____

Date	Time	Signature	M.D. ID #
_____	_____	_____	_____