# Pre-Anesthesia Progress Notes

Instruction to Patient: Please check your answer to each question. If you do not understand any questions (or your answer is uncertain) simply place a (?) in the "yes or no" column. These answers will help your anesthesiologist to give you the best care.

Name______________________________ Patient aware of copay amount $__________ Nurse initials

Date of surgery____________________ Surgeon_______________________________________

| Height (ft) (inch) | Weight | BMI | Age | | Family Medical Doctor |
|---|---|---|---|---|---|
| | | | | | |

| Have you had or do you still have: | Yes | No |
|---|---|---|
| Chronic Bronchitis, cough, emphysema | □ | □ |
| Asthma | □ | □ |
| Shortness of breath or other lung trouble | □ | □ |
| TMJ, Jaw disorders, or neck arthritis | □ | □ |
| Arthritis, Rheumatoid, Osteoarthritis | □ | □ |
| Heart murmur | □ | □ |
| Heart failure | □ | □ |
| High blood pressure | □ | □ |
| Chest pain, angina | □ | □ |
| Heart attack(s) | □ | □ |
| Cardiac catheterization | □ | □ |
| Pacemaker | □ | □ |
| Stents | □ | □ |
| Palpitations, irregular or fast heartbeat | □ | □ |
| ICD(intra cardiac defibrillator) | □ | □ |
| Jaundice, Hepatitis or other liver disease | □ | □ |
| Thyroid trouble | □ | □ |
| Kidney disease or failure | □ | □ |
| Epilepsy | □ | □ |
| Hiatal hernia, reflux, excessive heartburn | □ | □ |
| Neurologic problems such as stroke, numbness, weakness | □ | □ |
| Diabetes | □ | □ |
| Motion sickness/ear problems | □ | □ |
| Anemia | □ | □ |
| Bleeding tendency, easy bruising | □ | □ |
| Would you accept blood transfusions if necessary | □ | □ |
| Other illnesses not listed above | □ | □ |
| History of MRSA/staph infection | □ | □ |
| History of blood clots | □ | □ |
| History of HIV (AIDS) | □ | □ |
| History of hepatitis | □ | □ |
| History of long term prednisone usage | □ | □ |

**Anesthesia evaluation**

1. Chart reviewed
2. Pt interviewed
3. ASA-PS- I II III IV V E
4. Preferred plan GA, Spinal, Regional, Neuroleptic, MAC
5. □ NPO after midnight □ NPO/Other______________

□ Tobacco use

□ Previous tobacco use? When did you quit?

□ Alcohol use___Never ___Occasional ___Daily

□ Illegal drug use

□ What Last used

□ False teeth/bridges □ Loose/chipped teeth

□ Bonded/capped teeth

**For Women**

Is there any chance you are pregnant? □□ Yes □ No

When was your last mentrual period?

History of total hysterectomy? □□ Yes □ No

**Other Medical Information**

Are you allergic to latex (rubber) or similar things? □ Yes □ No

Have you or any member of your family had any unusual reactions to anesthesia, i.e. fever or prolonged paralysis? □ Yes □ No

Have you ever been told that you could not be intubated? Or were a difficult intubation (placement of breathing tube)? □ Yes □ No

Are you allergic to metal? □ Yes □ No

Patients Signture Date/Time

Staff Signature Date/Time

MD/DO

Anesthesia Sign Off Date/Time

Anesthesia Notes