Sarasota Physicians Surgical Center Pre Anesthetic Form

PATIENT LABEL

Procedure: _____

Height: _____ Weight: _____ (kg): _____

☐ **Check this box if you do NOT take any medications.**

Are you allergic to latex? ☐ Yes ☐ No (If you are allergic, notify the nurse when you are admitted.) ☐ Latex questionnaire completed

Allergies and reactions:

_____

_____

_____

List all your previous surgeries:

_____

_____

_____

List ALL your medications including over-the-counter, vitamins and herbal supplements on the chart below:

Name of Medication	Dose	How Taken? (by mouth, etc.)	How Often?	Reason For Taking This Medication	Last Taken First Visit	Continue After Discharge First Visit	Last Taken Second Visit	Continue After Discharge Second Visit

Driver's Name _____ **Telephone** _____ **Patients, please continue to fill out back page.**

First Visit (for office use)		Second Visit (for office use)	
Pre Op _____	Circulator _____	Pre Op _____	Circulator _____
Anesthesiologist _____	PACU _____	Anesthesiologist _____	PACU _____
CRNA _____	Surgeon _____	CRNA _____	Surgeon _____

Cardiovascular Disease

Heart Attack ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Arrhythmias or Palpitations ☐ Yes ☐ No
Heart Failure ☐ Yes ☐ No
Valve Disease or Heart Murmur ☐ Yes ☐ No
Pacemaker or Defibrillator ☐ Yes ☐ No
Shortness of Breath When Climbing Stairs ☐ Yes ☐ No
Other _____
When was your last cardiology visit ? _____

Neurological Disease

Seizures/Epilepsy ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Mini-Stroke ☐ Yes ☐ No
Muscle Disease ☐ Yes ☐ No
Neck/Back Pain ☐ Yes ☐ No
Motion Sickness ☐ Yes ☐ No
Other _____

Blood Disease

Sickle Cell Anemia ☐ Yes ☐ No
Clotting or Bleeding Problems ☐ Yes ☐ No
Other _____

Pediatrics

Prematurity ☐ Yes ☐ No
Congenital Abnormalities ☐ Yes ☐ No
Other _____

Anesthesia Problems

Difficult Intubation ☐ Yes ☐ No
Family History of Anesthesia Problems ☐ Yes ☐ No
Malignant Hyperthermia (You or Your Family) ☐ Yes ☐ No
Difficulty Opening Jaw ☐ Yes ☐ No
Post Op Nausea/Vomiting ☐ Yes ☐ No

Pulmonary Disease

Asthma ☐ Yes ☐ No
Emphysema or COPD ☐ Yes ☐ No
Lung Surgery ☐ Yes ☐ No
Bronchitis or Chronic Cough ☐ Yes ☐ No
Recent Respiratory Infection ☐ Yes ☐ No
Sleep Apnea or CPAP ☐ Yes ☐ No
Oxygen Use _____ Liters

Endocrine Disease

Diabetes (High Blood Sugar) ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
Other _____

Infectious Disease

MRSA or VRE ☐ Yes ☐ No
HIV ☐ Yes ☐ No
Hepatitis or Jaundice ☐ Yes ☐ No

Cancer

Previous cancers: _____
_____
_____

GI Disease

Acid Reflux or GERD ☐ Yes ☐ No
Hiatal Hernia ☐ Yes ☐ No
Other _____

Kidney Disease

Kidney Failure ☐ Yes ☐ No
Last Dialysis _____

Hearing and Vision

Hearing Aids ☐ Yes ☐ No
Other Aid to Hearing _____
Glasses or Contacts ☐ Yes ☐ No

Substance Use

Do you or have you used recreational drugs? ☐ Yes ☐ No
Last Use _____

Alcohol Use

Last Use _____

Smoking History

☐ Yes ☐ No Packs Per Day? ____ Last time smoked? _____
Years of Smoking _____ Quit When? _____

Mobility/Assisted Devices Used

Assistance Needed To Walk ☐ Yes ☐ No
☐ Cane ☐ Walker ☐ Wheelchair Other _____

Languages Spoken

☐ English ☐ Spanish Other _____
Language Line Needed ☐ Yes ☐ No
Interpreter's Name _____

Advance Directive ☐ Yes ☐ No

If yes, please bring a copy on the day of your surgery.

Religious/Cultural Belief

_____

Pain Level

What is your current pain level? ____ (0 = No Pain, 10 = Highest Pain)
Location of Pain _____

Dental

Missing, Loose or Chipped Tooth or Teeth ☐ Yes ☐ No
Dentures ☐ Yes ☐ No
Fixed Bridge ☐ Yes ☐ No

Sarasota Physicians Surgical Center

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