

PRE-ANESTHETIC EVALUATION
PATIENT QUESTIONNAIRE:
What Procedure is being done today? _____

(To be completed by patient, family member, or responsible party. Please review and mark any problems you may have now, or have had in the past.)

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fainting/Blackout | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Loose/Chipped Teeth |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Seizure | <input type="checkbox"/> Steroid Use | <input type="checkbox"/> False Teeth/Caps |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Leg Pain/Cramps | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Neck Pain/Stiffness |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Nerve Injury | <input type="checkbox"/> Radiotherapy | <input type="checkbox"/> Difficulty Opening Mouth |
| <input type="checkbox"/> Unable to Exercise | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Liver Problems | _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Back Injury | <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Sinus | <input type="checkbox"/> Neck Injury | <input type="checkbox"/> Jaundice | _____ |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Recent Cold/Flu | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Hiatal Hernia | _____ |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Weakness | <input type="checkbox"/> Frequent Heartburn | _____ |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcers | _____ |

Tobacco: No / Yes Amount: _____ Packs / Day for _____ Years

Alcohol: No / Yes Amount: _____

Street / Recreational Drugs: No / Yes Types: _____

Could you be pregnant? No / Yes

Start date of last menstrual period ____ / ____ / ____

Ever tested for AIDS or HIV? No / Yes Results: _____

Drug Allergies: _____

Medications: _____

List any medical problems not listed above: _____

List previous surgery: _____

Problems with anesthesia: No / Yes

- | | |
|---|---|
| <input type="checkbox"/> Family History of Problems | <input type="checkbox"/> Hoarseness/Sore Throat |
| <input type="checkbox"/> High Temperature | <input type="checkbox"/> Muscle Soreness |
| <input type="checkbox"/> Allergic Reaction | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Delayed Awakening | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Prolonged Weakness | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Nausea and Vomiting | <input type="checkbox"/> Difficulty w/ Breathing Tube |

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge, I am aware that my answers could affect my healthcare, or that of the patient for whom I am responsible

Date: ____ / ____ / ____ Relationship: _____ Signature of Patient, Parent, or Responsible Party: X _____

NURSING ASSESSMENT: (To be completed by nurse)

Age: _____ Height: _____ Weight: _____ Blood Pressure: _____ / _____ P: _____ R: _____ T: _____ C/F O2 Sat RA: _____ %

Questionnaire reviewed with patient/family; patient's history and health status as noted above, Additional notes by nurse: _____

Signature of Nurse: _____ Date: ____ / ____ / ____ Time: ____ : ____ a.m. / p.m. Additional comments on separate sheet.

ANESTHESIA PRE-OPERATIVE EVALUATION: Must be completed by Anesthesia Provider. Immediately prior to surgery.

Questionnaire review with patient/family; patient's history and health status as noted above. Additional comments including pertinent findings from history, physical exam, and diagnosis tests: _____

Physical Examination: C-V system: _____ Lungs: _____

PRE-OPERATIVE TEST RESULTS: Labs _____ ECG: _____ CXray: _____

Impression: ASA Classification: 1 2 3 4 5 E

NPO Status: _____

Airway: _____

Problem List: _____

Plan: _____

Premed: _____

Monitors: Routine: _____

I have discussed the anesthetic plan, alternatives, benefits, risks, and complications with the patient (or responsible party). Questions have been invited and answered. Patient or the guardian understands and consents Additional comments on separate sheet.

CRNA: _____ ANESTHESIOLOGIST: _____ Time: ____ : ____ a.m. / p.m.

Date: ____ / ____ / ____

PRE-ANESTHETIC EVALUATION
Questionario Paciente:: Que procedimiento se esta haciendo hoy?

(Ser terminado el paciente, el miembro de la familia, o el partido responsable. Por favor la revisión y marca cualquier problema que usted pueda tener ahora, o lo ha tenido en el pasado).

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Tensión arterial Alta | <input type="checkbox"/> Anemia | <input type="checkbox"/> Embolia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Problemas Del Riñon |
| <input type="checkbox"/> Enfermedad cardiaca | <input type="checkbox"/> Transfusión De Sangre | <input type="checkbox"/> El desmayarse/Apagón | <input type="checkbox"/> Problemas De la Tiroides | <input type="checkbox"/> Dientes Flojos/Saltados |
| <input type="checkbox"/> Ataque Del Corazon | <input type="checkbox"/> Dolor Del Pecho | <input type="checkbox"/> Epilepsia | <input type="checkbox"/> Usa Esteroides | <input type="checkbox"/> Dientes/Casquillos Falsos |
| <input type="checkbox"/> Problemas De Respiracion | <input type="checkbox"/> Calambres De la Perna/ Dolor de Pierna | <input type="checkbox"/> Problemas Medtales | <input type="checkbox"/> Latidos del Corazón irregulares | <input type="checkbox"/> Dolor De Cuello/Tiesura Del Cuello |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asma | <input type="checkbox"/> Dolor de cabeza/Migranta | <input type="checkbox"/> Quimioterapia | <input type="checkbox"/> Voz Ronca |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bronquitis | <input type="checkbox"/> Lesion Del Nervio | <input type="checkbox"/> Radioterapia | <input type="checkbox"/> Dificultad Para Abrir La Boca |
| <input type="checkbox"/> Incapez ejercitar | <input type="checkbox"/> Corto de la respiración | <input type="checkbox"/> Paralisis | <input type="checkbox"/> Problemas Del Hgado | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fiebre Reumática | <input type="checkbox"/> Pulmonia | <input type="checkbox"/> Lesion Dorsal | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tos Crónica | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Lesion Del Cuello | <input type="checkbox"/> Ictericia | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tendencia De Sangrado | <input type="checkbox"/> Frio/Gripe Reciento | <input type="checkbox"/> Hernia en el Disco | <input type="checkbox"/> Hernia Hiatal | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hemofilia | <input type="checkbox"/> Enfisema | <input type="checkbox"/> Debilidad | <input type="checkbox"/> Acidez Frecuente | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Contusion Fácil | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Artritis | <input type="checkbox"/> Úlceras | <input type="checkbox"/> _____ |

Tabaco: No / Si Cantidad: _____ Paquetes por día Por _____ Años

Alcohol: No / Si Cantidad: _____

Drogas Calle/Recreacionales: No / Si Types: _____

¿Podria usted estar embarazada? No / Si

Fecha incial de su ultimo periodo menstrual _____ / _____ / _____

A Sido Evakuado en conra del SIDA or el VIH? No/Si

Resultados: _____

Alergia A la Medicina: _____

Medicamento _____

Enumere cualquier problema médico no enumerado arriba: _____

Enumere sum as reciento Cirugia: _____

Problemas con anestesia: No/ Si _____

- | | |
|--|---|
| <input type="checkbox"/> Antecedentes familiars do problemas | <input type="checkbox"/> Voz Ronca / Garganta Dolorida |
| <input type="checkbox"/> De Alta temperatura | <input type="checkbox"/> Dolor Del Múscolo |
| <input type="checkbox"/> Reaccion Alérgica | <input type="checkbox"/> Ictericia |
| <input type="checkbox"/> El Despertar Retrasado | <input type="checkbox"/> Dolor de cabeza |
| <input type="checkbox"/> Debilidad Prolongada | <input type="checkbox"/> Sangrado Excesivo |
| <input type="checkbox"/> Nausea y vomito | <input type="checkbox"/> Dificultad con el tubo para respirar |

He repasado completamente el cuestionario y he contestado a todas las preguntas verazmente y al mayor de mi conocimiento, estoy enterado de que mis respuestas podrian afectar mi cuidado medico, o del paciente de quien soy responsable.

Fecha _____ / _____ / _____ Relación: _____ Firma del paciente, del padre o de la parte responsable: X _____

NURSING ASSESSMENT: (To be completed by nurse)

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Problem List: _____ *I have discussed the anesthetic plan, alternatives, benefits, risks, and complications with the patient (or responsible party). Questions have been invited and answered. Patient or the guardian understands and consents* Additional comments on separate sheet.

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Date: _____ / _____ / _____