BSA

PATIENT MEDICAL HISTORY / **ANESTHESIA** EVALUATION FORM

Have you had or are you being treated for: (Circle Yes or No:)

Yes No —Heart trouble
Yes No —Pacemaker
Yes No —ICD (bring your card) *(Internal Cardiac Defibrillator)*
Yes No —High blood pressure
Yes No —Lung disease/Asthma
Yes No —Stroke (*Paralysis?* _____*)*
Yes No —Cancer
Yes No —Epilepsy or seizures
Yes No —Cerebral Palsy/Previous Head Injury/Birth Defect
Yes No —Diabetes Diabetic Dr. _____
Yes No —Thyroid disease
Yes No —Jaundice or hepatitis
Yes No —Bleeding tendency
Yes No —Kidney disease *Dialysis on: (Circle one)* *M W F T T S*
Yes No —Liver disease
Yes No —Muscular Dystrophy/Multiple Sclerosis/Lupus
Yes No —Do you currently have a head/chest cold?
Yes No —Muscle weakness
Yes No —Arthritis
Yes No —Back trouble
Yes No —Neck trouble
Yes No —Nervous system disease
Yes No —Fainting or Dizziness
Yes No —Glaucoma
Yes No —Stomach problems *(Hiatal Hernia/heartburn/ indigestion)*
Yes No —Sleep apnea *(bring CPAP machine/mask)*
Yes No —TMJ problems *(Temporomandibular Joint: Jaw)*
Yes No —False or loose teeth
Yes No —Bridges
Yes No —Dental caps
Yes No —Contact lens
Yes No —Hearing Aid

ALLERGIES: (food, medicines, etc.) Type of reaction:

_____
_____
_____
_____

COMMENTS:_____
_____
_____

Have you taken or used any of the following in the last year? (Circle Yes or No:)

Yes No —Alcoholic beverages
Yes No —Steroids
Yes No —Diet drugs
Yes No —Recreational drugs (i.e., marijuana, etc.)
Yes No —Blood thinners _____ date stopped
Yes No —Tobacco _____ pks/day

Anesthesia History

Date of last anesthesia: _____
Yes No —Abnormal reactions?
Yes No —Nausea, vomiting?
Yes No —Relatives with abnormal reactions to anesthetics?

Medications: (Includes vitamins and herbal)

Name	mg	How often?

Weight: _____ lbs Height: _____

Past Surgical Procedures and Hospitalizations:

_____
_____
_____
_____

Patient/Guardian Signature _____

FOR WOMEN ONLY:
Yes No —Are you pregnant? Yes No —Still Menstruating?
—Date of Last Period Yes No —Had a Hysterectomy?
Yes No Had a Tubal for Sterilization?

Name of person taking you home _____

Relationship: _____

FOR USE BY ANESTHESIOLOGIST/PHYSICIAN

PRE-ANESTHESIA ASSESSMENT

_____
_____
_____
_____
_____
_____
_____
_____
_____

ASA Classification

❑ Class I ❑ Class II ❑ Class III ❑ Class IV ❑ Class V

Type of Anesthesia:

❑ General ❑ Regional
❑ Spinal ❑ Epidural
❑ Monitored Anesthesia Care

Physician's/Licensed Independent Practitioner's Statement:

I have discussed the anesthetic plan with the patient/guardian including risks/benefits/alternatives of the anesthetic plan. The patient has had all questions answered and has agreed to proceed.

I have completed a reassessment immediately before induction of anesthesia/sedation, and the patient remains a candidate for the anesthetic plan.

_____ _____
Certified Registered Nurse Anesthetist (CRNA) Date

_____ _____
Anesthesiologist/Physician) Date

POST-ANESTHESIA

Recovery satisfactory: _____
_____
_____

Complications: _____
_____
_____

_____ _____
Certified Registered Nurse Anesthetist (CRNA) Date

_____ _____
Anesthesiologist/Physician Date

PATIENT STICKER

OP1010