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

- Heart trouble
- Pacemaker
- ICD (bring your card) *(Internal Cardiac Defibrillator)*
- High blood pressure
- Lung disease/Asthma
- Stroke *(Paralysis?)*
- Cancer
- Epilepsy or seizures
- Cerebral Palsy/Previous Head Injury/Birth Defect
- Diabetes. Diabetic Dr.
- Thyroid disease
- Jaundice or hepatitis
- Bleeding tendency
- Kidney disease (Dialysis on: (Circle one) M W F T T S)
- Liver disease
- Muscular Dystrophy/Multiple Sclerosis/Lupus
- Do you currently have a head/chest cold?
- Muscle weakness
- Arthritis
- Back trouble
- Neck trouble
- Nervous system disease
- Painting or Dizziness
- Glaucoma
- Stomach problems *(Hiatal Hernia/heartburn/indigestion)*
- Sleep apnea *(bring CPAP machine/mask)*
- TMJ problems *(Temporomandibular Joint: Jaw)*
- False or loose teeth
- Bridges
- Dental caps
- Contact lens
- Hearing Aid

**ALLERGIES:** (food, medicines, etc.)

Type of reaction:

- **YES**
- **NO**

**COMMENTS:**

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**FOR USE BY ANESTHESIOLOGIST/PHYSICIAN**

**PRE-ANESTHESIA ASSESSMENT**

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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.

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

- Alcoholic beverages
- Steroids
- Diet drugs
- Recreational drugs (i.e., marijuana, etc.)
- Blood thinners
- Tobacco

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)

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Weight: **lbs**  Height: ****

**Past Surgical Procedures and Hospitalizations:**

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**FOR WOMEN ONLY**

- Are you pregnant?
- Date of Last Period
- Still Menstruating?
- Had a Date
- Hysterectomy?
- Had a Tubal for Sterilization?

Name of person taking you home

Relationship:

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**CERTIFYING ANESTHESIOLOGIST/PHYSICIAN**

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:

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Complications:

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Certified Registered Nurse Anesthetist (CRNA) Date

Anesthesiologist/Physician Date

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**PATIENT STICKER**