

## TAMPA OUTPATIENT SURGICAL FACILITY ANESTHESIA EVALUATION

Surgical Procedure: _____				Age: _____		Ht.: _____		Wt.: _____						
PLACE AN "X" IN THE PROPER COLUMN:				YES	NO	DON'T KNOW	PLACE AN "X" IN THE PROPER COLUMN:			YES	NO	DON'T KNOW		
1. DO YOU HAVE TO TAKE ANTIBIOTICS TO PROTECT YOUR HEART BEFORE SURGERY?							11. HAVE YOU EVER HAD ANY DIGESTIVE TRACT PROBLEMS?		ULCERS/HIATAL HERNIA					
2. DO YOU SMOKE? PPD _____ YRS. _____ QUIT _____									ACID REFLUX					
3. DO YOU USE RECREATIONAL DRUGS?							12. HAVE YOU EVER HAD ANY MUSCLE OR JOINT PROBLEMS?		ARTHRITIS					
4. DO YOU DRINK ALCOHOL?									BROKEN BONES					
5. DO YOU HAVE ANY LOOSE, CAPPED, OR FALSE TEETH?									LIMITED JOINT MOVEMENT					
6. DO YOU WEAR CONTACT LENSES?							13. HAVE YOU EVER HAD ANY METABOLIC PROBLEMS?		DIABETES					
7. HAVE YOU EVER HAD ANY HEART PROBLEMS?		HIGH BLOOD PRESSURE							THYROID DISEASE					
		LOW BLOOD PRESSURE					14. HAVE YOU EVER HAD A TIA OR CVA?							
		RHEUMATIC FEVER					HEAD INJURY, HEADACHES, NUMBNESS OR TINGLING IN EXTREMITIES, CONVULSIONS/EPILEPSY?							
		HEART ATTACK					15. HAVE YOU OR ANY FAMILY MEMBERS EVER HAD ANY PROBLEM WITH AN ANESTHETIC?							
		HEART MURMUR					MALIGNANT HYPERTHERMIA?							
		CHEST PAIN/ANGINA					16. ARE YOU PREGNANT?							
		IRREGULAR HEART BEAT					HAD A HYSTERECTOMY OR TUBAL LIGATION?							
		CHF					17. DO YOU HAVE ANY HISTORY OF ANY CANCERS? PLEASE LIST							
8. HAVE YOU EVER HAD ANY LUNG PROBLEMS?		ASTHMA/WHEEZING					18. HAVE YOU EVER HAD ANY SURGERIES? PLEASE LIST							
		BRONCHITIS OR PNEUMONIA												
		SHORTNESS OF BREATH												
		CPAP/O2												
9. HAVE YOU EVER HAD ANY URINARY PROBLEMS?		SLEEP APNEA					19. DO YOU HAVE ANY ALLERGIES? PLEASE LIST							
		URINARY INFECTIONS												
		KIDNEY STONES												
10. DO YOU HAVE ANY INFECTIOUS DISEASES?							PHYSICAL EXAMINATION / DOS		ASA#	1	2	3	4	5
HEPATITIS		HIV		TB		MRSA		(IF SO, PLEASE CIRCLE)						
PREGNANCY TEST _____								AIRWAY						
DATE: _____ BY: _____								HEART						
ACCU CHECK: _____ MG/DL (NORMAL RANGE 70 - 110 MG/DL)								LUNGS						
DATE: _____ BY: _____								<input type="checkbox"/> LABS/EKG/CXR REVIEWED NPO _____ HRS.						
								PROPOSED ANESTHESIA _____						
								PAIN MANAGEMENT /HEALTH STATUS UNCHANGED						
								DATE		SIGNATURE				
								_____		_____				
								_____		_____				
								_____		_____				
<input type="checkbox"/> PT REQUESTS ANESTHETIC SEDATION (MAC/GETA)														
<input type="checkbox"/> DR REQUESTS ANESTHESIA PRESENCE 2 <sup>o</sup> TO MEDICAL STATUS														
<input type="checkbox"/> PT & SURGEON REQUESTS POST-OP PAIN MANAGMENT														
<input type="checkbox"/> ANESTHESIA HAS REVIEWED EVALUATION WITH PATIENT & ADDRESSED CONCERNS														
_____ ANESTHESIOLOGIST'S SIGNATURE:				_____ DATE										
										PATIENT STICKER				

