EPS SURGICAL CENTER, LLC

PRE-ANESTHESIA NURSING ASSESSMENT

Patient Name: _____

Height: _____ Weight: _____ Age: ____

Date: _____

Surgeon: _____

Have you traveled outside of the United States in the last 30 days or had contact with anyone who has traveled outside of the United States in the last 30 days? □ YES □ NO

If yes: Where did you travel?_____

Who is your regular M.D.? _____When was your last visit? _____

Is this your first Anesthetic □ Yes □ No

Have you or your family had any problems with previous anesthesia? □ Yes □ No

Explain: _____

Are you allergic to Latex? □ Yes □ No

If YES, what is your reaction to Latex? _____

Are you allergic to Iodine? □ Yes □ No What was your reaction? _____

Are you allergic to Adhesive? □ Yes □ No What was your reaction? _____

Are you allergic to any Foods? □ Yes □ No

If YES, what food and what is your reaction to the food? _____

Are you allergic to any medications? □ Yes □ No

If YES, please list the drug and the reaction in the spaces provided below.

MEDICATION TO WHICH YOU ARE ALLERGIC	WHAT WAS YOUR REACTION TO THE DRUG?

Do you have or have you ever had any of the following:

☐ Heart Disease	☐ Muscle Weakness	☐ Nose Surgery	☐ Diabetic
☐ Lung Disease	☐ Obstructive Sleep Apnea	☐ Use a CPAP	☐ COPD/Emphysema
☐ Chest Pain	☐ Blood Transfusion	☐ Bowel/Colon Disease	☐ Hiatal hernia/Ulcers
☐ High Blood Pressure	☐ Back/Neck Problems	☐ Broken Facial Bones	☐ Hepatitis
☐ Asthma	☐ Shortness of Breath	☐ Liver Disease	☐ Pregnant
☐ Glaucoma	☐ Chronic Cough	☐ Claustrophobia	☐ Renal/Kidney Disease
□ Restless Leg Syndrome	☐ Bleeding/Clotting abnormalities	☐ Urinary Retention	

(SEE BACK)

Pain assessment scale: 1 2 3 4 5 6 7 8 9 10 (1 = no pain, 10 = most pain)

Are you the past or present carrier of a contagious disease? _____

Smoker: □ YES □ NO Amount: _____ Alcohol: □ YES □ NO Amount: _____

Have you had (past or present) a dependency on: Smoking: □ YES □ NO Alcohol/Drugs: □ YES □ NO

What type of Diet do you follow? □ Regular □ Diabetic □ Other: _____

Cortisone/Steroids in the past year? □ YES □ NO

Do you have any of the following: □ Dentures □ Bridgework □ Partial Plates □ Contact Lenses
□ Caps □ Hearing Aids

Past Surgeries: _____

Medical/Surgical Problems: _____

Please list all the medications you take on a regular basis. (Over the counter medications, vitamins and those prescribed by your physician)

MEDICATION	DOSAGE (STRENGTH)	HOW OFTEN

DO NOT WRITE BELOW THIS LINE

ANESTHESIA ASSESSMENT: NPO SINCE: _____

TYPE OF ANESTHESIA: □ MAC □ OTHER ASA I II III

Head and Neck:

Lungs

Heart:

Anesthesiologist Signature Date/Time