EPS Surgical Center, LLC
Eye Physicians & Surgeons, PC
Pre-Anesthesia Assessment

Please complete the attached form and make sure you bring with you to your pre-op appointment.

It is very important that you answer all the questions to the best of your knowledge.

It is important that we are made aware of allergies to any medications and to latex, iodine, adhesives and foods.

All medications that you take on a regular basis, including any over the counter medications and vitamins must be listed on the form with the dosage (such as 500 mg) and how often you take them (such as once per day).

If you have any questions, please call us at (404) 292-2500.

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

EPS Surgical Medical Clearance Form

Medical clearance is needed from your primary care physician **before your date of surgery.**

Your primary care physician should complete the attached form.

Please print a copy and take to your primary care physician's office for them to complete. **We ask that you assist us in ensuring your primary care physician completes this form in a timely manner.** If you are unable to take to their office, please direct them to our website at www.atlantaeye.com, and click on **Surgical Patient Forms**.

Upon completion of the form, please fax to:
Attention: VIP Services
Fax # (404) 294-3353
Alternate Fax # (404) 294-9361

If you have any questions, please contact us via phone at (404) 292-2500.

Charles W. McDowell, MD
Peter A. Gordon, MD
Paul E. McManus, MD
John W. Thomas, MD
Laura A. Bealer, MD
Indira Menon, MD
Christina L. Weeks, MD
Ajeet Dhingra, MD
Shalin Shah, MD

EYE PHYSICIANS & SURGEONS, PC
1457 Scott Blvd – Decatur, GA 30030 Fax: 404-294-3353

MEDICAL CLEARANCE

Dear Dr. _____ Phone: _____ Fax: _____

Dear Dr. _____ Phone: _____ Fax: _____

The patient listed below is scheduled for EYE SURGERY in the near future.
SHOULD YOU CHOOSE TO SEE THIS PAITNET IN YOUR OFFICE TO PROVIDE SURGICAL CLEARANCE, PLEASE HAVE YOUR OFFICE CONTACT THE PATIENT DIRECTLY.
Please fax your evaluation AND any supporting documentation as soon as possible as this information must be obtained by my office in order to proceed with surgery.
**If you have any questions, please call (404) 292-2500, ask for a Surgical Coordinator
If you use EMR or your records are relatively legible, please send with this form.
Simply state if the patient is cleared for surgery, sign and attach your supporting information.

PATIENT'S NAME: _____

PATIENT'S PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ PRE-OP DATE: _____

DIAGNOSIS: _____ SURGERY DATE: _____

PROPOSED SURGERY: _____

ANESTHESIA: _____

Significant past medical history: _____

_____

_____

_____

_____

MUST HAVE CURRENT MEDICATION LIST (INCLUDING DOSAGES) FOR MEDICAL RECONCILIATION_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List of previous operations: _____

_____

_____

Drug Allergies: _____

_____

_____

BLOOD PRESSURE: _____ PULSE: _____

HEENT: _____

LUNGS: _____

CARD / VASC: _____

ABD _____

EXT _____

NEURO / PSYCH _____

DIAGNOSES _____

REMARKS _____

IS THIS PATIENT CLEARED FOR SURGERY? ☐ YES ☐ NO

DATE: _____ SIGNED: _____, MD