

Please fill out this form by checking the appropriate boxes and placing explanatory comments in the space provided

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- 1 Have you ever undergone anesthesia before?
- 1a Have you or any family members had major problems (severe nausea, high fever, breathing difficulty) after anesthesia?

Do you now have or have you ever had:

<input type="checkbox"/>	<input type="checkbox"/>	2 Diabetes?	<input type="checkbox"/> On Pills	<input type="checkbox"/> On Insulin?
<input type="checkbox"/>	<input type="checkbox"/>	3 High Blood Pressure?	<input type="checkbox"/> On Medicine?	
<input type="checkbox"/>	<input type="checkbox"/>	4 Cardiovascular Disease:	<input type="checkbox"/> Angina/Chest Pain	
		<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Irregular heart beat/Pacer	
		<input type="checkbox"/> Valve disease/Murmur (including Mitral Valve Prolapse)		
		<input type="checkbox"/> Prior heart surgery/angioplasty		
		<input type="checkbox"/> Heart attack	<input type="checkbox"/> Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	5 Lung disease:	<input type="checkbox"/> Emphysema	
		<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Asthma/Wheezing	

Please complete the back of this form if you answered "Yes" to any part of questions 2 through 5

Anesthesia Comments

<input type="checkbox"/>	<input type="checkbox"/>	6 Neuromuscular Disease:	<input type="checkbox"/> Muscle weakness
		<input type="checkbox"/> Paralysis	<input type="checkbox"/> Seizures
		<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/>	<input type="checkbox"/>	7 Kidney disease?	<input type="checkbox"/> On Dialysis?
<input type="checkbox"/>	<input type="checkbox"/>	8 Liver disease?	<input type="checkbox"/> Hepatitis/Jaundice?
<input type="checkbox"/>	<input type="checkbox"/>	9 History of abnormal bleeding?	<input type="checkbox"/> Blood transfusion?
<input type="checkbox"/>	<input type="checkbox"/>	9a Have you donated blood for this procedure?	
<input type="checkbox"/>	<input type="checkbox"/>	10 Hiatal Hernia?	<input type="checkbox"/> Acid Reflux?
<input type="checkbox"/>	<input type="checkbox"/>	11 Back problems or chronic headaches?	<input type="checkbox"/> Motion Sickness?
<input type="checkbox"/>	<input type="checkbox"/>	12 Have you had a cold, "flu" or fever within the past week?	
<input type="checkbox"/>	<input type="checkbox"/>	13 Could you be pregnant? Last menstrual period?	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	14 Do you smoke? Packs per day?	<input type="text"/>
		Years smoking <input type="text"/>	Quit when? <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	15 Do you drink alcohol? Drinks/beers per day?	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	16 Have you taken oral or IV steroids within the past 6 months?	
<input type="checkbox"/>	<input type="checkbox"/>	17 Do you take any of the following medications: "Fen-Phen", Redux, Glucophage, Aspirin, Coumadin You <u>may</u> need to discontinue these before surgery	
<input type="checkbox"/>	<input type="checkbox"/>	18 Do you have loose teeth, caps, bridges or other dental work?	

MATERIAL RISKS: Georgia law requires that material risks be disclosed to you. These include but are not limited to: Infection, allergic reaction, scarring, blood loss requiring transfusion with associated risk of AIDS and/or hepatitis, loss of function of any limb or organ, paralysis, brain damage, cardiac arrest or death. **OTHER RISKS:** Anesthetic procedures may also result in lung injury, headache, backache, or trauma to adjacent structures.

By signing below, you acknowledge that you have read and understand these risks.

Do you have any other medical problems not listed above?
None _____

Please describe any drug or latex allergies
None _____

Please list all medications you are taking (including "over-the-counter")
None _____

PLEASE DO NOT WRITE BELOW THIS LINE

X

Signature of person completing form _____

Procedure _____

Surgeon _____

Height _____ ft in/cm

Weight _____ lbs/kg

Anesthesia Plan: General MAC Regional Epid Narc A-Line CVP PAC

The anesthetic plan, procedures and risks were discussed with patient/family who understand and agree.

Date _____ Time _____ MD _____

PreAnesthesia Summary: I have seen and examined this patient and reviewed the anesthetic plan	NPO > 8 hrs?	Yes	No	ASA	1	2	3	4	5	E	Hb/Hct	/	
	SMA	Not Req	WNL	Abnl							ECG	Not Req	WNL
	CXR	Not Req	WNL	Abnl									
Remarks													
Date	Time	Anesthesiologist								MD			

Please answer the questions below to help us better understand your state of health

1 Please check the most strenuous activity you are able to perform:

- Take care of yourself at home
- Walk around the house
- Do light housework
- Walk up a hill or climb a flight of steps
- Play golf, jog or dance
- Exercise strenuously

Yes No

- 2 Do you see a Primary Care Physician on a regular basis?
 2a Who is your Doctor? _____
 2b Has he or she evaluated you for this surgical procedure?
 Please summarize the results of your evaluation or provide a copy:

- 3 Have you undergone Cardiac Surgery (such as Coronary Artery Bypass Grafting) or Angioplasty in the last 5 years?
 3a Procedure? _____
 3b When? _____
 3c Have you had any recurrent symptoms since that time?

- 4 Have you been evaluated by a cardiologist within the past 2 years?
 4a Has he or she performed any tests (cardiac cath, echo, or thallium scan)?
 4b Please summarize the results of your evaluation or provide a copy:

Thank you for helping us prepare for your anesthetic
Piedmont Anesthesia Associates