FOR PHYSICIAN USE ONLY

PRE-OPERATIVE ANESTHESIA FORM
WILMINGTON SURGCARE

_____ y.o. male/female scheduled for _____
(procedure)

By Dr. _____ on _____
(surgeon) (date of surgery)

Physical Exam: BP_____ P_____ R_____ T_____ HT_____ WT_____

Dental - Normal ❑ Denies: ❑ GERD ❑ Angina ❑ SOB ❑ DOE ❑ PND ❑ Orthopnea
Lungs - Clear To Auscultation ❑
Heart - RRR ❑ Comments: _____
Neurologic - Grossly Physiologic Exam ❑
No Carotid Bruits ❑
Normal Neck Movement ❑
Normal Airway ❑
Allergies: _____

LAB RESULTS: HGB _____ HCT _____ OTHER _____

CHEST X-RAY _____ ECG _____

PLAN: ❑ MAC ❑ GENERAL ❑ SPINAL ❑ AX BLOCK ❑ IV REGIONAL ❑ ANKLE BLOCK ❑ OTHER _____

INTRA-OP: ❑ RSI ❑ Glidescope ❑ GCS (Teds) ❑ IPC (SCD)

POST OP PAIN CONTROL: ❑ B.P. ❑ Femoral ❑ Popliteal ❑ Other _____

_____

Evaluated by _____ MD Date _____ Time _____

DAY OF SURGERY

NPO_____ Hours ASA: I II III IV V Preop Meds _____

Consent Signed ❑ History and Physical Reviewed ❑ Responsible Adult Present ❑

Comments _____

Evaluated by _____ MD Date _____ Time _____

POSTOPERATIVE ANESTHESIA NOTE

Pacu score of 8 or greater ❑
No Nausea or Vomiting; or Nausea is under control with Medication ❑
Ambulated without dizziness, has good motor control ❑
Has taken and retained oral fluids ❑
Has voided without difficulty ❑
Understands Discharge Instructions ❑
Discharged: Home with Responsible Adult ❑ To Recovery Care ❑ To Hospital ❑ Other ❑

COMMENTS _____

The following questions are to be answered by or on behalf of the patient scheduled for surgery. If the patient scheduled for surgery presently has, or ever has had in the past, any of the following medical conditions, please check "yes" in the appropriate space. Check "no" in the appropriate space for negative answers.

LUNG	YES	NO
Born with any lung disease	☐	☐
Cough or cold at present time	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Home Oxygen _____ Liters / Min	☐	☐
Smoke _____ Packs of cigarettes per day for the past _____ years.	☐	☐

HEART		
Born with any heart disease	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
High blood pressure	☐	☐
Skipped heartbeats	☐	☐
Chest pains	☐	☐
Hardening of the arteries	☐	☐
Heart failure	☐	☐
Heart attacks	☐	☐
Heart Stent (DES/BMS)	☐	☐
Exercise Tolerance (Climb 2 flights of stairs without shortness of breath)	☐	☐

BLOOD		
Sickle cell trait or disease	☐	☐
Other disease of blood cells	☐	☐
Abnormal blood clotting	☐	☐
Frequent nose bleeds	☐	☐

KIDNEY		
Born with kidney disease	☐	☐
Kidney infections	☐	☐
Kidney Stones	☐	☐
Kidney failure	☐	☐

NERVOUS SYSTEM		
Born with nervous system abnormality	☐	☐
Brain disease	☐	☐
Spinal cord disease	☐	☐
Nerve disease	☐	☐
Epilepsy/Seizures	☐	☐
Stroke	☐	☐

SPINAL STENOSIS		
Cervical / thoracic / lumbar	☐	☐

ENDOCRINE	YES	NO
Diabetes	☐	☐
Thyroid Disease or Goiter	☐	☐
Have you taken steroids such as cortisone or prednisone within the last year?	☐	☐

EYE		
Glaucoma	☐	☐
Contact lenses	☐	☐

REPRODUCTIVE		
Female: Are you pregnant?	☐	☐

DENTAL		
Bridges	☐	☐
Crowns	☐	☐
Dentures	☐	☐
Loose Teeth	☐	☐

AIRWAY		
Problem opening mouth wide	☐	☐
Problem turning head in any direction	☐	☐
Do you get heartburn when you lie down?	☐	☐

MRSA		
	☐	☐

DO YOU HAVE ANY PAST OR PRESENT HEALTH PROBLEMS NOT INDICATED ABOVE?		
	☐	☐

ANESTHETIC HISTORY		
Allergic to any drug used in dental work, anesthesia or surgery	☐	☐
Any blood relative have any allergy to any drug used in anesthesia	☐	☐
How many times have you been anesthetized for surgery in the past?_____		
Date of last anesthetic_____		
Any problems resulting from any anesthetic ever administered to you.	☐	☐

PATIENT'S SIGNATURE _____ **DATE** _____
(Or Guardian)

Wilmington SurgCare

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