Have you had? (Patient to complete)

1. Heart problems, congestive heart failure, heart attack, high blood pressure, heart murmur, abnormal electrocardiogram, blood clot, pacemaker/defibrillator — Yes □ No □
2. Lung disease: asthma, emphysema, bronchitis, abnormal chest x-ray, tuberculosis, sleep apnea. — Yes □ No □
3. Seizure, glaucoma, nervous system disease, stroke, muscle weakness, paralysis. — Yes □ No□
4. Jaundice, hepatitis, cirrhosis. — Yes □ No □
5. Kidney of bladder disease, stones, or severe infection — Yes □ No □
6. Metabolic problems: diabetes, thyroid, adrenal, etc. — Yes □ No □
7. Back injuries or surgery, broken bones. — Yes □ No □
8. Stomach or intestinal problems, ulcers, colitis, hiatal hernia, reflux, gastric — Yes □ No □
9. Blood transfusions: Date ______________ — Yes □ No □
10. Objections to blood transfusions. — Yes □ No □
    Even if your life is in danger? — Yes □ No □
11. Appropriate blood transfusion refusal form signed. — Yes □ No □
12. Blood disease, abnormal bleeding tendencies. — Yes □ No □
13. Anticoagulant therapy (Blood thinners). — Yes □ No □
14. Have you been tested for HIV/AIDS? — Yes □ No □
15. Are you pregnant? Maybe □ — Yes □ No □
    Last menstrual period date? ___________
16. Other medical illness _________________ — Yes □ No □
17. Have a history of DVT/PE? — Yes □ No □

Age ___________ Height ___________ Weight ____________

When did you last have anything to eat or drink?________________________________

Medication or Food Allergies:

NONE □

____

____

Do you:

1. Smoke? No □ Yes □ Packs/day _____ for _____ years
   Quit smoking? Date _____________
2. Use alcohol? None □ Socially □ Moderately □ Heavily □
3. Have a history of substance abuse? — Yes □ No □
4. Wear eyeglasses? Yes □ No □ Wear contacts? — In □ Out □
5. Dentures: ☐Upper ☐Lower Bridges: ☐Upper ☐Lower Caps: ☐Upper ☐Lower
   None ☐
6. Loose or damaged teeth: ☐Upper ☐Lower None ☐
7. **List previous surgeries and dates:**

____

____

8. Have a problem to discuss with an anesthesiologist? — Yes □ No □
9. Have you ever had an abnormal anesthetic reaction? — Yes □ No □
10. Do you have any relative with abnormal anesthetic reactions? — Yes □ No□

Medications/Herbs/Vitamins: (List all medications/dose taking)

____

____

I understand this information is important to my medical care and is correct.

____

Patient Signature Date/Time

Anesthesia Evaluation (Anesthesia to complete)

Date ________________ Time _______________ NPO _______________

Rx medication(s) before surgery:_______________________

History:____

____

____

____

____

____

____

____

____

Physical: Time: _________________________

CV____

Pulm____

Neuro____

Anesthesia benefits/options with attendant risk and complications discussed with patient/family. Questions answered. Yes □ No □

Procedure proposed:____

____

Dental/Airway:

Plan _________________ Informed consent given by ______________

CRNA: ____

Anesthesiologist:____

Admit to Recovery Date:__________________ Time: ___________

O_2 sat ______% BP ________ P _______ R ______ Temp ______°

CRNA: ____

Anesthesiologist: ____

Time care turned over to PACU nurse: __________________________

Post Anesthesia Evaluation

Date:________________ Time: ________________

O_2 sat ______% BP ________ P _______ R ______ Temp ______°

Neuro/LOC: □ WNL ____

CV: □ WNL ____

Pulm: □ WNL____

Complications: □ None____

____

____

____

Anesthesiologist:____

Oklahoma Kidney Stone Center
Anesthesia Questionnaire and Evaluation