

PREANESTHESIA EVALUATION		Age	Sex M F	Height in / cm	Weight lb / kg						
Proposed Procedure		Pre-Procedure Vital Signs B/P P R T									
Previous Anesthesia / Operations	None <input type="checkbox"/>	Current Medications			None <input type="checkbox"/>						
Family History of Anesthesia Complications	None <input type="checkbox"/>	Allergies			NKDA <input type="checkbox"/>						
AIRWAY / TEETH / HEAD & NECK				History From: <input type="checkbox"/> Patient <input type="checkbox"/> Significant Other <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Chart <input type="checkbox"/> Communication / Language Problems <input type="checkbox"/> Poor Historian							
SYSTEM	WNL	COMMENTS		DIAGNOSTIC STUDIES							
RESPIRATORY Asthma Productive Cough Bronchitis Recent URI COPD SOB Dyspnea Tuberculosis Orthopnea Pneumonia	<input type="checkbox"/>	Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Packs / Day for _____ Years		EKG							
CARDIOVASCULAR Abnormal EKG Hypertension Angina MI ASHD Murmur CHF Pacemaker Dysrhythmia Rheumatic Fever Exercise Tolerance Valvular Disease	<input type="checkbox"/>			Chest X-ray							
HEPATO / GASTROINTESTINAL Bowel Obstruction Cirrhosis Hepatitis / Jaundice Hiatal hernia / Reflux Nausea & Vomiting Ulcers	<input type="checkbox"/>	Ethanol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency _____ *Street Drug* Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency _____		Pulmonary Studies							
NEURO / MUSCULOSKELETAL Arthritis Muscle Weakness Back Problems Neuromuscular Dis. CVA / Stroke / TIAs Paralysis DJD Paresthesia Headaches / ↑ ICP Syncope Loss of Consciousness Seizures	<input type="checkbox"/>			Other							
RENAL / ENDOCRINE Diabetes Renal Failure / Dialysis Thyroid Disease Urinary Retention Urinary Tract Infection Weight Loss / Gain	<input type="checkbox"/>			LABORATORY STUDIES							
OTHER Anemia Immunosuppressed Bleeding tendencies Pregnancy Cancer Sickle Cell Dis. / Trait Chemotherapy Recent Steroids Dehydration Transfusion History Hemophilia	<input type="checkbox"/>			Hgb / Hct / CBC							
Problem List / Diagnoses		<div style="display: flex; align-items: center; justify-content: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">PHYSICAL STATUS</div> <table border="1" style="border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;">1</td></tr> <tr><td style="width: 20px; height: 20px;">2</td></tr> <tr><td style="width: 20px; height: 20px;">3</td></tr> <tr><td style="width: 20px; height: 20px;">4</td></tr> <tr><td style="width: 20px; height: 20px;">5</td></tr> <tr><td style="width: 20px; height: 20px;">E</td></tr> </table> </div>				1	2	3	4	5	E
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2											
3											
4											
5											
E											
Planned Anesthesia / Special Monitors											
Pre-Anesthesia Medications Ordered											
Evaluator Signature											
Date											
Time											
Signed _____ Date _____ Time _____											
Patient Identification											