FASTMD
Florida Advanced Spine and Sports Trauma Centers

# ANESTHESIA PRE-OPERATIVE ASSESSMENT

Email completed form to Jayme Haverty at Jhaverty@fastmd.com

| Patient Name | | Date | | Age |
|---|---|---|---|---|
| Family doctor | Cardiologist Last Visit | Pain Management Doctor | | Other Doctor |

**ALLERGIES** (Include medications, food, tape, iodine, latex) **If you don't have allergies check here:** ☐ **No known allergies**

| 1. | 2. | 3. | 4. | 5. | 6. |
|---|---|---|---|---|---|

**List of Daily MEDICATIONS** (Including Over-The-Counter Medications and Dietary/Herbal Supplements

| Medication and Dose | Frequency | Medication and Dose | Frequency | Medication and Dose | Frequency |
|---|---|---|---|---|---|
| 1. | | 5. | | 9. | |
| 2. | | 6. | | 10. | |
| 3. | | 7. | | 11. | |
| 4. | | 8. | | 12. | |

**List of SURGERIES** (Include all surgeries and angioplasties)

| Surgery | Year | Surgery | Year | Surgery | Year | Surgery | Year |
|---|---|---|---|---|---|---|---|
| 1. | | 3. | | 5. | | 7. | |
| 2. | | 4. | | 6. | | 8. | |

**Do you have or have you had any of the following? Check all that apply**

□ High blood pressure □ Rheumatic Fever □ Murmur
□ Heart Attack / MI Date _____ □ Congestive Heart Failure □ Palpitations
□ Chest pain / Angina □ Irregular Heart Beat □ Dizziness / Fainting
□ ICD / Pacemaker Model _____ □ Open Heart Surgery □ Blood clots / Phlebitis

**Do you take blood thinners? Check all that apply**

□ Coumadin Last taken _____ □ Plavix Last taken _____ □ Aspirin Last taken _____
□ Lovenox Last taken _____ □ Other Last taken _____

**Have you had any of the following tests in the past? Complete all that apply**

Date of last **EKG** _____ Where? _____
Date of last **Stress Test** _____ Where? _____
Date of last **Echo** _____ Where? _____
Date of last **Cardiac Cath** _____ Stent? □ Yes □ No Where? _____
Date of last **Pacemaker / Defibrillator** Check _____ Where? _____
Date of last **Chest X-Ray** _____ Where? _____

**Do you or have you had any of the following? Check all that apply**

□ Asthma □ COPD / Emphysema □ Cold or Flu past 2 weeks □ Bronchitis
□ Cough □ Shortness of breath □ Pneumonia past 2 months
□ Sleep apnea □ CPAP / BIPAP □ Oxygen at home _____
Do you: □ Snore □ Stop breathing in your sleep □ Have daytime sleepiness

**Do you or have you had any of the following? Check all that apply**

□ Diabetes. If yes, controlled by □ Insulin □ Pills □ Diet
□ Kidney Disease Check all that apply: □ Renal failure □ Dialysis □ Insufficiency □ Stones
□ Liver Disease, Hepatitis or yellow jaundice
□ Difficulty swallowing, esophageal cancer or esophageal surgery
□ Cancer? If yes, type _____ Date _____ □ Chemotherapy □ Radiation
□ Gastric Ulcer □ GERD (Reflux) □ Hiatal Hernia □ HIV or AIDS

**Height_____**
**Weight _____**
**BMI:_____**
**Contact Information _____**

Place Patient ID Label Here

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**Do you have or had you had any of the following? Check all that apply**

□ Thyroid Disease □ Anemia □ Bleeding Problems □ Arthritis
□ Seizures. If yes, last one _____ □ Stroke Date _____ □ TIA
□ Mental Illness □ Depression □ Other _____

**Do you have any of the following?**

□ Dentures □ Crowns □ Caps □ Bridge □ Loose, chipped, or broken teeth
□ Contacts □ Glasses □ Cataracts □ Glaucoma □ Eye implants
□ Total joint/prosthesis: Type _____
□ Cochlear implant □ Insulin pump □ Pain pump □ Other Implant _____

| Yes | No | |
|---|---|---|
| ☑ | ☐ | Have you or a blood relative ever had a problem with anesthesia? |
| ☐ | ☐ | Have you ever been told you had a difficult intubation? |
| ☐ | ☐ | Do you have a history of motion sickness or nausea / vomiting after surgery? |
| ☐ | ☐ | Are you being treated for a chronic pain condition? |
| ☐ | ☐ | Are you sensitive to pain medication or sleeping pills? |
| ☐ | ☐ | Are you claustrophobic or do you have an anxiety conditions? |
| ☐ | ☐ | Do you consume alcohol? How much? _____ |
| ☐ | ☐ | Do you use recreational drugs? □ Occasional □ Daily Type _____ |
| ☐ | ☐ | Do you smoke or did you ever smoke? How many years? _____<br>How much? □ ½ pack/day □ 1 pack/day □ 2 pack/day<br>When did you quit? _____ |
| ☐ | ☐ | Do you vape or use E-Cigarette? |
| ☐ | ☐ | If female, are you pregnant or think you could be? Last menstrual period? _____ |
| ☐ | ☐ | Do you have difficulty walking? Do you use? □ Cane □ Walker □ Wheelchair |
| ☐ | ☐ | Do you have difficulty walking two blocks at a normal pace? |
| ☐ | ☐ | Do you have difficulty walking up two flights of stairs? If yes, Why?_____ |
| ☐ | ☐ | Do you sleep on more than one pillow? If yes, Why?_____ |
| ☐ | ☐ | Do you wake up suddenly short of breath? |
| ☐ | ☐ | Are you currently in a drug study? Name of drug _____ |
| ☐ | ☐ | Have you traveled outside the US in the past month |
| ☐ | ☐ | Have you had any recent infections or prescribed any antibiotics or had any recent dental work? |

Form completed by □ Patient □ Other: _____

☐ **Reviewed by Physician**
**Cleared for Anesthesia**
☐ **YES**
☐ **NO**

Preoperative Anesthesia Provider: _____

Date _____ Time _____

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