PRE-ANESTHESIA RECORD

INSTRUCTION TO PATIENT: *Please print your answer to each question. These answers will greatly help your anesthesiologist to give you the best possible care during your operation.*

Name:______________________ Age:__________ Sex:________

Height:______________ Weight:__________ lbs

❑ Right Handed (Mano Derecha)
❑ Left Handed (Mano Izquierda)

Medications/Vitamins/Supplements taken in the last 30 days.

Medication Name	Dose	Frequency

*Place additional medications on separate sheet of paper.

Allergy Alerts/Reactions.

What are you allergic to (medications/food/latex/tape)?	Describe reaction.

List all previous surgeries and approximate dates.

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

PRE-ANESTHESIA RECORD

	Yes	No		Yes	No		Yes	No
Acid Reflux	❑	❑	Hernia	❑	❑	Others not mentioned:	❑	❑
AIDS	❑	❑	High Blood Pressure	❑	❑		❑	❑
Anemia	❑	❑	High Cholesterol	❑	❑		❑	❑
Arthritis	❑	❑	Kidney Disease	❑	❑		❑	❑
Asthma	❑	❑	Liver Disease	❑	❑	Are you pregnant? N/A ❑	❑	❑
Back Problems	❑	❑	Muscle Disease	❑	❑	Previous history of MRSA?	❑	❑
Blackout	❑	❑	Neuropathy	❑	❑	Do you have an advanced directive?	❑	❑
Bleeding Tendencies	❑	❑	Osteoporosis	❑	❑			
Blood Transfusion	❑	❑	Palpitations	❑	❑	Any history of suicidal ideation?	❑	❑
Cancer Type:____________	❑	❑	Prostate Problems	❑	❑			
Cataract	❑	❑	Rheumatic Fever	❑	❑	Have you been threatened or physically hurt by someone within the past year?	❑	❑
Chest Pain/Angina	❑	❑	Seizures,	❑	❑			
Chronic Cough	❑	❑	Last Episode:___________________					
COPD	❑	❑	Shortness of Breath	❑	❑	Any history of domestic abuse?	❑	❑
Diabetes	❑	❑	Sickle Cell Anemia	❑	❑			
Emphysema	❑	❑	Sleep Apnea	❑	❑	Have you been a participant in a clinical trial: Diabetic, Asthma, CHF, Oncology, Stroke, Pneumonia, Other?	❑	❑
Fibromyalgia	❑	❑	Snoring	❑	❑			
Glaucoma	❑	❑	Stiff Jaw or Neck	❑	❑			
Gout	❑	❑	Stroke	❑	❑			
Heart Attack	❑	❑	Thyroid Problem	❑	❑			
Heart Murmur	❑	❑	TIA	❑	❑			
Hepatitis Type:____________	❑	❑	Ulcers	❑	❑			

Whats the reason for the procedure?

In your own words what is the procedure/Surgery?

Any high or unexplained fever during or after surgery?

	Yes	No
Patient	❑	❑
Family	❑	❑

Any unusual reaction to anesthesia? Please choose which:

❑ Nausea ❑ Fever ❑ Vomiting ❑ Blood Pressure Problem ❑ Slow to awaken

Others:____

	Yes	No
Patient	❑	❑
Family	❑	❑

Religious Preferences: ____

Assistive Devices: ❑ None ❑ Wheelchair ❑ Cane ❑ Walker ❑ Crutches
❑ Other: ____

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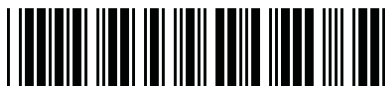

OP1023

DESERT SPRINGS HOSPITAL
MEDICAL CENTER

PRE-ANESTHESIA RECORD

(PMM# 78522943) (R 1/13) (FOD)

PATIENT IDENTIFICATION

PRE-ANESTHESIA RECORD

Emergency Contact Name	Relationship	Phone No.

Name of Family Physician

Primary Language: ❑English ❑Spanish ❑Other:

Immunizations: Pneumonia vaccine ❑ No ❑ Yes, Date:____
Flu vaccine ❑ No ❑ Yes, Date:____

Have you ever been exposed or had symptoms of Tuberculosis? ❑ No ❑ Yes, Date:____________________

Family History:	Mother	Father	Brother	Sister
None ❑				
Cancer	❑	❑	❑	❑
Cardiac	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑

Bladder: ❑ Normal ❑ Urgency ❑ Retention
❑ Dribbling ❑ Frequency ❑ Incontinence ❑ Foley
❑ Blood in Urine ❑ Nephrostomy ❑ Urostomy

Bowel: ❑ Normal ❑ Diarrhea ❑ Constipation
❑ Pain ❑ Blood ❑ Hemorrhoids ❑ Ileostomy
❑ Colostomy

Dialysis ❑ No ❑ Yes

Tobacco: ❑ Never
❑ No Year quit___________
❑ Yes Cigarettes per day__________ How long___________

Alcohol: ❑ No
❑ Yes How much _______________ What kind__________________ # of years ________________

Drugs: ❑ Never
❑ No Year quit ______________
❑ Yes Type ______________________

Do you have any of the following?	
❑ Pacemaker ❑ Defibrillator ❑ AICD	Site:
❑ Body Piercing	Site:
❑ Fistula or AV graft	Site:
❑ Metals, pins, screws, rods in your body	Site:
❑ Any other foreign body	Site:

Discharge:
Home environment: ❑ Live alone ❑ With family ❑ With friend ❑ Homeless

Name of person taking you home:	Relationship:	Telephone #:

Reviewed By:

Patient Signature Date/Time RN Signature Date/Time

BAR CODE

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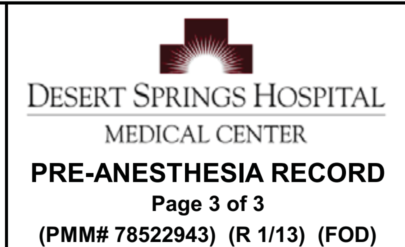

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