

**STOP**

MRC approved 01/13/10 595-023

History from: <input type="checkbox"/> Patient <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Significant Other		<input type="checkbox"/> Chart <input type="checkbox"/> Poor Historian <input type="checkbox"/> Language Barrier		PRE-ANESTHESIA EVALUATION		<input type="checkbox"/> See previous anesthesia record dated _____ for information	
PROPOSED PROCEDURE				AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	HEIGHT in / cm	WEIGHT lb / kg
PREVIOUS ANESTHESIA / OPERATIONS / COMPLICATIONS <input type="checkbox"/> NONE				CURRENT MEDICATION(S) <input type="checkbox"/> NONE <input type="checkbox"/> Hx Herbal / OTC drug use <input type="checkbox"/> Hx Illicit drug use			
AIRWAY	<input type="checkbox"/> MP1 <input type="checkbox"/> T-M distance = _____ <input type="checkbox"/> Morbid obesity <input type="checkbox"/> Edentulous ↑ ↓ <input type="checkbox"/> MP2 <input type="checkbox"/> M-O distance = _____ <input type="checkbox"/> Hx difficult airway <input type="checkbox"/> Facial hair <input type="checkbox"/> MP3 Neck FULL LIMITED NONE <input type="checkbox"/> Teeth poor repair / loose <input type="checkbox"/> Short muscular neck <input type="checkbox"/> MP4 ROM <input type="checkbox"/> Micrognathia <input type="checkbox"/> Prominent incisors			ALLERGIES / REACTION <input type="checkbox"/> NONE			
	SYSTEM				COMMENTS		DIAGNOSTIC STUDIES
	<input type="checkbox"/> WNL RESPIRATORY Asthma / RAD Recurrent tonsillitis Bronchiolitis Recurrent OM COPD Recent URI Emphysema TB / +PPD Bronchitis Pneumonia Respiratory failure Productive cough Pleural effusion SOB / Dyspnea Pulmonary embolism OSA Sinusitis / Rhinitis Orthopnea Environ. allergies Wheezing				TOBACCO USE: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Packs / Day for _____ Years <input type="checkbox"/> Quit _____  Pre-procedure Pulmonary Physical Exam		ECG:
	<input type="checkbox"/> WNL CARDIOVASCULAR Hypertension Abnormal ECG Hyperlipoproteinemia Cardiomyopathy CAD Hypovolemia Angina Pacemaker Stable / Unstable AICD Myocardial infarction Murmur CHF DOE PND Valvular Dz / MVP Peripheral Vascular Dz Hx Rheumatic fever Exercise Tolerance Endocarditis METs: >4 <4 Aneurysm				Pre-procedure Cardiac Physical Exam		
<input type="checkbox"/> WNL HEPATO / GASTROINTESTINAL Obesity N & V Cirrhosis / Liver Dz Diarrhea Hepatitis / Jaundice IBS / Chron's Dz Bowel obstruction Pancreatitis Ulcers Gallbladder Dz Hiatal hernia Diverticulum GERD Colon polyps				ETHANOL USE: <input type="checkbox"/> No <input type="checkbox"/> Yes Frequency _____ <input type="checkbox"/> Hx ETOH abuse <input type="checkbox"/> Quit _____		LABORATORY STUDIES	
<input type="checkbox"/> WNL NEURO / MUSCULOSKELETAL Arthritis / DJD / DDD Muscle weakness OA / RA / Gout Neuromuscular Dz Back Problems (LBP) Paralysis Scoliosis / Kyphosis Paresthesia(s) Headaches / Migraine CVA / TIA ↑ ICP / Head injury Seizures / Epilepsy ↓ LOC / Unconscious Psychiatric disorder						T&S / T&C:  HCG: U/A: LMP:	
<input type="checkbox"/> WNL RENAL / ENDOCRINE Thyroid disease Prostate Bladder Dz / tumor BPH / CA Renal stones UTI / Incontinence Renal insufficiency Diabetes mellitus: Renal Failure / Dialysis Type I / II / Gest. Adrenocortical insuff. Pituitary disorder							
<input type="checkbox"/> WNL OTHER Anemia Immunosuppressed Bleeding disorder Sickle Cell Dz / Trait Cancer Steroid use Chemotherapy Cushingoid Radiation Tx Sepsis / Infection Nonambulatory Transfusion Hx Eye Dz / Glaucoma Weight loss / gain HIV / AIDS Pregnant G6PD Deficiency Peripheral edema				FAMILIAL ANES PROBLEMS: <input type="checkbox"/> No <input type="checkbox"/> Yes Description _____			
SURGICAL DIAGNOSIS / PROBLEM LIST				PHYSICAL STATUS		PROVIDER	
				1 2 3 4 5 E		DATE	
				CONTROLLED MEDICATIONS		TIME	
				MEDICATION USED DESTROYED RETURNED			
PLANNED ANESTHESIA Special Monitors / Airway / Concerns: <input type="checkbox"/> GA <input type="checkbox"/> Epidural <input type="checkbox"/> Cont Spinal <input type="checkbox"/> Local / MAC <input type="checkbox"/> Caudal <input type="checkbox"/> CSE <input type="checkbox"/> Deep Sedation <input type="checkbox"/> SAB <input type="checkbox"/> Regional:				PROVIDER		WITNESS	
PRE-ANESTHESIA DIRECTIONS / MEDICATIONS				<input type="checkbox"/> NPO per ASA Guidelines		EVALUATOR / DATE:	
						EVALUATOR / DATE:	