CARLINVISION SURGERY CENTER, LLC
PRE-ANESTHESIA NURSING ASSESSMENT

Patient Name:_____
Date of Birth:_____

Today's Date: _____ **Surgeon:**_____

Who is your regular M.D.?_____ **When was your last visit?** _____

Phone number of regular M.D._____

Have you ever had anesthesia before? ☐ **YES** ☐ **NO**

Have you or your family had any problems with previous anesthesia? ☐ **YES** ☐ **NO**

Explain: _____

Are you allergic to Latex? ☐ **YES** ☐ **NO**

If YES, what is your reaction to Latex? _____

Are you allergic to Iodine? ☐ **YES** ☐ **NO** **What was your reaction?** _____

Are you allergic to Adhesive? ☐ **YES** ☐ **NO** **What was your reaction?** _____

Are you allergic to any Foods? ☐ **YES** ☐ **NO**

If YES, what food and what was your reaction to the food? _____

_____

Are you allergic to any medications? ☐ **YES** ☐ **NO**

If YES, please list the drug and the reaction in the spaces provided below.

MEDICATION TO WHICH YOU ARE ALLERGIC	WHAT WAS YOUR REACTION TO THE DRUG?

Do you have or have you ever had any of the following: (Please circle)

Heart Disease	**Muscle Weakness**	**Nose Surgery**	**Diabetes**
Lung Disease	**Chest Pain**	**Blood Transfusion**	**Bowel/Colon Disease**
High Blood Pressure	**Back/Neck Problems**	**Broken Facial Bones**	**Hiatal hernia/Ulcers /Gastric Reflux**
Asthma	**Shortness of Breath**	**Liver Disease**	**Hepatitis**
Pregnant	**Glaucoma**	**Chronic Cough**	**Bleeding/ Clotting abnormalities**

Restless Leg Syndrome **Communicable Disease (TB, MRSA, VRE, etc)** **Recent or current infection**

Pain assessment scale: **0 1 2 3 4 5 6 7 8 9 10 (0= no pain, 10=most pain)**

(Continued back of page)

Smoker: ☐ **YES** ☐ **NO** **Amount:** _____ **Alcohol:** ☐ **YES** ☐ **NO** **Amount** _____

Have you had (past or present) a dependency on: Smoking: ☐ **YES** ☐ **NO**

Alcohol/Drugs : ☐ **YES** ☐ **NO**

What type of diet do you follow? ☐ **Regular** ☐ **Diabetic** ☐ **Other:**_____

Height:_____ **Weight:**_____ **Age:**_____

Cortisone/Steroids in the past year? ☐ **YES** ☐ **NO**

Do you have any of the following? ☐ **Dentures** ☐ **Bridgework** ☐ **Partial Plates** ☐ **Contacts Lens** ☐ **Caps** ☐ **Hearing Aids**

Past Surgeries: _____

Medical/Surgical Problems: _____

Please list all the medications you take on a regular basis. (Over the counter medications, vitamins and those prescribed by your physician)

MEDICATION	DOSAGE (STRENGTH)	HOW OFTEN

DO NOT WRITE BELOW THIS LINE

ANESTHESIA ASSESSMENT: **NPO SINCE:**_____

TYPE OF ANESTHESIA: ☐ **MAC** ☐ **OTHER** **ASA I II III**

Head and Neck: _____

Lungs: _____

Heart: _____

Anesthesiologist Signature _____ **Date** _____ **Time** _____