Your Hospital's Logo Here

PRE-ANESTHETIC EVALUATION

PATIENT IDENTIFICATION

PATIENT NAME:	ROOM #:	SURGEON:	SCHEDULED TIME:
PROPOSED OPERATION:			

AGE:	SEX: ☐ M ☐ F	HT:	WT:	Hb:	Hct:	Wbc:	ALLERGIES:

CARDIOVASCULAR SYSTEM: HTN ANGINA, MI SOB, PND MURMUR DYSRHYTHMIA	ECG:
RESPIRATORY SYSTEM: SMOKING ASTHMA	CXR: ABGs:
GASTROINTESTINAL SYSTEM: HEPATITIS HIATAL HERNIA ETOH	NPO STATUS:
RENAL SYSTEM:	Na+ K+ Cl- CO_2 BUN Cr
ENDOCRINE SYSTEM: THYROID DM ADRENAL	GLUCOSE:
COAGULATION SYSTEM:	PLATELETS BLEEDING TIME PT PTT TT FSPs
CNS: SEIZURES STROKE HEAD INJURY	OTHER LAB TESTS:
OTHER: AIRWAY DENTAL	CURRENT MEDICATIONS:
PREVIOUS SURGERY:	Data Reviewed by: Date:
I HAVE DISCUSSED ANESTHESIA, INCLUDING OPTIONS & RISKS, WITH THIS PATIENT. PATIENT UNDERSTANDS & ACCEPTS. ☐ GENERAL ☐ REGIONAL ☐ MAC ANESTHESIOLOGIST'S SIGNATURE DATE (ELECTIVE PRE-OP REVIEW)	P S 1 2 3 4 5 E ANESTHESIOLOGIST'S SIGNATURE DATE (IMMEDIATELY PRE-OP IN O.R.)

PART OF THE MEDICAL RECORD