



APOGEE OUTPATIENT SURGERY CENTER ANESTHESIA INFORMATION

Name _____ Date _____

Age _____ Height _____ Weight _____ (lbs.) or _____ (kg) _____ BMI _____

Who is your family Doctor? _____

YES NO

Are you allergic to any medicine?

COMMENTS:

List allergies and reactions _____
Latex i.e.: rash, swelling, itching, respiratory problem after contact with
rubber products (balloons, rubber gloves, condoms). _____

Have you had previous surgery with general (sleep) anesthesia?
List at right dates and procedure(s).....

Have you had surgery with regional anesthesia (spinal, arm block, etc.)?
List.....

Have you ever had a problem with any anesthesia?
Explain.....

Has any blood relative had a problem with anesthesia?
(e.g.: death, prolonged paralysis, malignant hyperthermia, etc.)?.....

How many pillows do you sleep with under your head?.....

Have you ever had a resting electrocardiogram? If yes, with whom and when?.....

Name: _____ Date: _____

LIST MEDICATIONS:

DO YOU HAVE:

A Cardiologist?.....Who? _____

Cardiac disease (heart attack, heart disease)?.....

Arterial vascular (blood vessel) disease?.....

High blood pressure?.....

Kidney disease?.....

Convulsive disorder (epilepsy)?.....

Chronic lung disease (emphysema, tuberculosis, etc.)?.....

Asthma?.....

Breathing difficulties with lying flat on your back or climbing a flight of stairs?.....

Diabetes?

Chemo/Radiation

A bleeding tendency?.....

Loose teeth, capped teeth, orthodontic or other dental appliance, dentures?.....

Have you ever had a stroke?.....

Do you take medicine for your heart or diuretics?
List.....

Do you take any other medicine(s), HERBS, VITAMINS or DIET PILLS?
List.....

When was your last menstrual period?.....

Date _____

Are you pregnant?.....

Do you smoke or have ever smoked? If yes, how much and how often?.....

Do you drink Alcohol? If yes, how much and how often?.....

Any other important health problems or diseases i.e.:
MRSA, VRE, CDIFF, Hepatitis and/or any Blood Bacteria/Virus or immune diseases.

ANESTHESIOLOGIST EVALUATION AND PLAN

Date: _____

Procedure: _____

Additional History: _____

PHYSICAL EXAM

HEENT: _____ AIRWAY M I II III

CARDIAC: _____

LUNGS: _____

NEUROLOGICAL: _____

EXTREMITIES: _____

PROGRESS NOTES: _____

ASA# 1 2 3 4

Anticipated Anesthetic Technique: GA CSE REGIONAL BLOCK MAC _____

Doctor Signature