EMERALD COAST SURGERY CENTER
an affiliate of WHITE-WILSON MEDICAL CENTER, P.A.

Pre-Anesthetic Questionnaire

Patient name_____
Surgeon_____

Daytime phone # _____

Date of procedure: month____ **date** ____ **year** ____

DRUG & FOOD ALLERGIES: □ **none list:** _____

Procedure _____

_____

Tobacco use? Yes No_____packs/day x _____ years
Alcohol use? Yes No # drinks per week:_____

Latex allergy/sensitivity to tape/band-aids? **Circle: Yes No**

Height _____**Weight** _____**(pounds)**_____**(kg)**

Have pain? Yes No Where: ____1-2-3-4-5-6-7-8-9-10

Prior surgeries: _____

****ANESTHESIA PROBLEMS for you or any blood relative? Yes No If yes, explain:**_____

Which of the following do you have or have you had in the past?: Circle "YES" or "NO"

Chest pain……	**Yes**	**No**	**Thyroid disease**……	**Yes**	**No**	**DO YOU:**			
Heart attack……	**Yes**	**No**	**Liver disease**……..	**Yes**	**No**	**Wear contact lenses?**.....	**Yes**	**No**	
Heart failure ……	**Yes**	**No**	**Hepatitis**……	**Yes**	**No**	**Wear hearing aids?**.....	**Yes**	**No**	
Mitral valve prolapse…….. …..	**Yes**	**No**	circle type if yes: A B C			**Have body piercing?** (besides ears)	**Yes**	**No**	
Rheumatic fever……	**Yes**	**No**	**Anemia**……..	**Yes**	**No**	If yes, where?_____			
Heart murmur……..	**Yes**	**No**	**Bruise or bleed easily**…….	**Yes**	**No**	**Have dentures or partials?**.....	**Yes**	**No**	
Irregular heartbeats……	**Yes**	**No**	**Strokes**……	**Yes**	**No**	**Use cane, walker or wheelchair?**...	**Yes**	**No**	
Aneurysms……	**Yes**	**No**	If yes, do you have weakness?	**Yes**	**No**	**Have you had a fall before?**	**Yes**	**No**	
Heart catheterization or stents	**Yes**	**No**	**TIA (mini-stroke)**……	**Yes**	**No**	**Need a translator day of surgery?**			
Heart surgery (e.g. bypass)….	**Yes**	**No**	**Parkinsons' disease**……..	**Yes**	**No**	If yes, what language:_____	**Yes**	**No**	
Pacemaker/Defibrillator…….	**Yes**	**No**	**Seizures or epilepsy**……	**Yes**	**No**				
date it was last checked:_____			date of last seizure:_____			**Take blood thinners or anti-**			
Artificial heart valve……..	**Yes**	**No**	**Migraines**……..	**Yes**	**No**	**inflammatories?**.....			
High blood pressure……..	**Yes**	**No**	**Memory loss**……..	**Yes**	**No**	(Plavix, Coumadin, Aspirin, Motrin,	**Yes**	**No**	
Blood Clots in legs or lungs….	**Yes**	**No**	If yes, do you sign your papers?	**Yes**	**No**	Advil, Ibuprofen, Aleve, Naprosyn,			
Asthma……..	**Yes**	**No**	**Artificial joints, (hip, knee)**	**Yes**	**No**	Mobic,Celebrex, Aggrenox,etc.)			
Emphysema or COPD……..	**Yes**	**No**	**Back pain**……	**Yes**	**No**	**Did you stop this medication?**			
Chronic cough……	**Yes**	**No**	**Neck pain**……	**Yes**	**No**	**Date last taken:**_____	**Yes**	**No**	
Shortness of breath……	**Yes**	**No**	**Herniated discs**……..	**Yes**	**No**				
Home oxygen……..	**Yes**	**No**	**Cancer**……..	**Yes**	**No**	**WOMEN ONLY:**			
Sleep apnea and/or CPAP……	**Yes**	**No**	type:_____			Are you pregnant now?.....	**Yes**	**No**	
Tuberculosis……..	**Yes**	**No**	chemotherapy……	**Yes**	**No**	Are you breastfeeding now?.....	**Yes**	**No**	
Diabetes……..	**Yes**	**No**	radiation therapy……	**Yes**	**No**	Take hormones orTamoxifen?.....	**Yes**	**No**	
If yes, circle below:			**DO YOU:**			Ever had a tubal or hysterectomy?	**Yes**	**No**	
Insulin Pills Diet			**Have anything contagious?**	**Yes**	**No**				
Kidney disease……	**Yes**	**No**	(fever, cough rash, open **sores?**			_____			
If yes, are you on dialysis?	**Yes**	**No**	**Have MRSA, AIDS or HIV?**…	**Yes**	**No**	**Patient signature Date**			
Hiatal (esophagus) hernia…….	**Yes**	**No**	**Have night sweats?**……..	**Yes**	**No**				
Acid reflux……	**Yes**	**No**	**Use recreational drugs?**…….	**Yes**	**No**	_____ _____			
Ulcers……..	**Yes**	**No**	**Get preventative antibiotics**			**Nurse Signature Date**			
Weight loss……..	**Yes**	**No**	**before procedures?**.....	**Yes**	**No**	Nurse only:			
						DVT Mod/High Risk N/A Y / N			

Comments: Next of kin / emergency contact (name/phone number):

_____

_____

Day of surgery

Who is to receive D/C instructions?: _____**Who is to receive surgery results?:** _____

□ **Procedure verified, site verified Left / Right** □ **Pt. Notified of advance directive policy** □ **Social assessment**

□ **Patient questionnaire reviewed day of surgery** **Signature:** _____ **Date:** _____

Anesthesia history □ **Chart reviewed** □ **PAQ reviewed** □ **Patient interviewed** □ **Patient examined**

Anesthesia evaluation:

_____

_____

_____

_____**NPO**

after:_____

Lungs _____
Heart _____
□ **Labs Reviewed HCG** ⊖

MP Class I II III IV
Neck Ext.- FROM/Good/ Limited
Teeth □ **Intact** _____

ASA Status: 1 2 3 4 5 E.
Anesthetic: General Block
Bier MAC Spinal/Epidural

_____
Anesthesiologist Signature Date

Consent for Administration of Conscious Sedation
I understand that it will be necessary to be placed under conscious sedation so that my physician can perform the surgery or procedure. I consent to the use of conscious sedation as deemed necessary and appropriate by my physician.

Conscious Sedation Involves Risks In Addition to the Risks of the Surgical Procedure Itself
These risks may include, but are not limited to, adverse drug reactions, brain damage, nerve injury, damage to teeth or dental work, damage to vocal cords, respiratory problems, minor pain and discomfort, damage to arteries or veins, headaches, backaches or worsening of pre-existing disease(s). The purpose, necessity, and risks of conscious sedation have been explained to my satisfaction by _____M.D. and there has been sufficient opportunity to discuss the proposed treatment and associated risks.

I hereby consent to an alternative type of anesthesia, if necessary, as deemed appropriate by my physician. Alternative types of anesthesia will be provided by Broad Anesthesia Associates, all of whom are credentialed to provide anesthesia services at this health facility. I understand that conscious sedation is planned for my procedure, and that the anesthetic technique to be used is determined by many factors, including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthetic technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used, including general anesthesia. Although rare, unexpected severe complications with anesthesia can occur, and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia.

I understand that if I am pregnant or there is any possibility that I may be pregnant, I must inform the Surgery Center immediately since this could cause harm to my child or myself.
I DECLARE AND REPRESENT THAT I HAVE READ THE ABOVE AND UNDERSTAND IT IS TRUE. No guaranty or warranty had been made as to the result of the procedure and/or conscious sedation.

_____ _____
Patient's Signature (or person authorized to consent) Relationship to Patient

_____ _____
Witness Date/Time

To be Completed by Physician

Physical Exam
NPO after Midnight Yes / No
Lungs ☐ Un remarkable _____
Heart ☐ Unremarkable _____
Labs WNL Yes / No
ASA Status I II III IV

Physician
Cleared for Surgery Yes / No
Risks/Benefits Discussed Yes / No

Type of Anesthesia
Conscious Sedation / Local

Comments: _____

_____
Physician Signature (Conscious Sedation Only)

Straight Local
PAQ History Reviewed
Mental Status Assessed ☐

Comments : _____
_____
_____

_____
Physician Signature