Pasadena Surgery Center
Pre-Anesthetic Evaluation

Please fill out this form carefully and completely.
Bring to Pasadena Surgery Center on the day of surgery.

Patient Name: _____ **Procedure # 1:** _____
Height: _____ **Weight:** _____ **Procedure # 2:** _____

Are you allergic to latex? (***Please circle and notify the nurse on admission***) **Yes** **No**

List Other Allergies:

_____
_____
_____
_____

List ALL Previous Surgeries:

_____
_____
_____
_____

Do you take any blood thinners?

Aggrenox	❑ **NO**	❑ **YES** **Stopped when?**	First Visit _____	Second Visit _____
Coumadin	❑ **NO**	❑ **YES** **Stopped when?**	First Visit _____	Second Visit _____
Plavix	❑ **NO**	❑ **YES** **Stopped when?**	First Visit _____	Second Visit _____
Aspirin	❑ **NO**	❑ **YES** **Stopped when?**	First Visit _____	Second Visit _____
Motrin, etc	❑ **NO**	❑ **YES** **Stopped when?**	First Visit _____	Second Visit _____
Arthritis med	❑ **NO**	❑ **YES** **Stopped when?**	First Visit _____	Second Visit _____

List Below ALL your other medications including over-the-counter, vitamins, & herbal supplements.

Name of Medication	**Dose**	**How taken** *(by mouth, etc.)*	**How often**	**Reason for taking this medication**	**Last taken?**	**Last Taken?**
☐ **Check this box if you do not take any medications**					Visit 1	Visit 2

Answer YES or NO for EACH DISEASE

YES NO Cardiovascular Disease
- ☐ ☐ Heart Attack
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Chest Pain
- ☐ ☐ Arrhythmias or Palpitations
- ☐ ☐ Heart Failure
- ☐ ☐ Valve Disease/Heart Murmur
- ☐ ☐ Pacemaker/Defibrillator
- ☐ ☐ Shortness of Breath When Climbing Stairs

Other: _____

YES NO Neurological Disease
- ☐ ☐ Seizures/Epilepsy
- ☐ ☐ Stroke
- ☐ ☐ Mini-Stroke/TIA
- ☐ ☐ Muscle Disease
- ☐ ☐ Neck/Back Pain

Other: _____

YES NO Blood Disease
- ☐ ☐ Sickle Cell Anemia
- ☐ ☐ Clotting/Bleeding Problems

Other: _____

YES NO Pulmonary Disease
- ☐ ☐ Asthma
- ☐ ☐ Emphysema/COPD
- ☐ ☐ Lung Surgery
- ☐ ☐ Bronchitis/Chronic Cough
- ☐ ☐ Recent Respiratory Infection
- ☐ ☐ Sleep Apnea

Other: _____

YES NO Endocrine Disease
- ☐ ☐ Diabetes (high blood sugar)
- ☐ ☐ Thyroid Problems

Other: _____

YES NO Infectious Diseases
- ☐ ☐ MRSA / VRE
- ☐ ☐ HIV
- ☐ ☐ Hepatitis/Jaundice

YES NO GI Disease
- ☐ ☐ Acid Reflux / GERD
- ☐ ☐ Hiatal Hernia

Other: _____

YES NO Kidney Disease
- ☐ ☐ Kidney Failure

Last dialysis: _____

Other: _____

YES NO
- ☐ ☐ Recreational Drugs

Last use? _____

- ☐ ☐ Alcohol

Last use? _____

Smoking History:
- ☐ **NO**
- ☐ **YES** _____ Packs / Per day _____ Years
- ☐ **QUIT WHEN?** _____

YES NO
- ☐ ☐ Difficult Intubation
- ☐ ☐ Family History of Anesthesia Problems
- ☐ ☐ Malignant Hyperthermia (You or Your Family)
- ☐ ☐ Difficulty with Jaw Opening

Other: _____

YES NO Teeth
- ☐ ☐ Missing/Loose/Chipped Tooth or Teeth
- ☐ ☐ Dentures
- ☐ ☐ Fixed Bridge

Other: _____

Comments:
_____
_____

Visit 1 **Date:** _____
Reviewed by Anesthesiologist _____

Reviewed by Nurse _____

Visit 2 **Date:** _____
Reviewed by Anesthesiologist _____

Reviewed by Nurse _____

_____ _____
Patient Signature **Date**

_____ _____
Patient Signature **Date**

Patient Label