ADVANCED SURGERY CENTER
12607 OLIVE BLVD.
ST. LOUIS, MO 63141

ANESTHESIA PRE-OPERATIVE ASSESSMENT

PLEASE COMPLETE THIS FORM

AND BRING TO THE CENTER

Directions to Patients:

1. Please complete this form for the Anesthesia staff who will review it with you prior to your surgery.
2. Proper completion of this form is important and will help to minimize the risks associated with anesthesia.
3. This form must accompany you to the center. Please do not mail it to the center.
4. A member of the anesthesia staff will meet you pre-operatively and answer all your questions.

1. Proposed surgery

   _____

2. Recent hospitalizations/surgery (within two years) / surgery

   _____
   _____
   _____
   _____
   _____

3. Significant medical problems (check the conditions that apply):
   - ____ High blood pressure
   - ____ Chest pain, angina, any cardiac problems
   - ____ Other heart conditions
   - ____ Hepatitis/liver trouble
   - ____ Ulcers, previous abd. surgery, any GI problems, gastric reflux
   - ____ Asthma, shortness of breath, emphysema
   - ____ Kidney problems
   - ____ Diabetes or endocrine problems
   - ____ Bleeding tendency
   - ____ Nervous disorders, strokes, seizures, etc.
   - ____ Skeletal or muscle problems
   - Other _____

4. Describe your use of:
   Tobacco_____
   Alcohol _____
   Non-prescription/social drugs _____
   _____

5. Are you currently (please check):
   - ____ Pregnant
   - ____ Suffering from: a cold, sore throat, any infection

6. Hours since last food or drink intake_____

7. What medications do you take at home? (Please list name and dose of each):

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

8. Please list any drug allergies.
   Drug _____
   Describe type of drug reaction _____
   _____

9. Previous anesthetics - have you had any unusual reaction to anesthetics?
   ____ Yes ____ No
   Please describe_____
   _____
   Have any relatives had unusual reactions to anesthetics?
   ____ Yes ____ No
   Please describe _____
   _____

10. Do you have any dental implants, crowns, bridges, etc., loose or damaged teeth?

    _____

PHYSICIAN - ANESTHESIA TO COMPLETE THIS PORTION

I affirm that I have reviewed the above information, pertinent physical findings, and available medical records and provided the above-named patient and/or authorized representative with complete and current information regarding anesthesia plan, including a discussion of the risks, benefits, alternatives, and likely outcomes. She/he consents to this procedure and accepts all risks.

_____
_____
_____

Anesthesia Plan _____ ASA _____ Date _____ Time _____

Physician Signature _____ Airway_____

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