

# Anesthesia Assessment - Jacksonville Surgery Center

Name \_\_\_\_\_ Date of Surgery: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Planned Procedure: \_\_\_\_\_

Daily Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Latex Allergy?  Yes  No (check one)

Yes	No	HAVE YOU HAD OR STILL HAVE?	Yes	No	HAVE YOU HAD OR STILL HAVE?
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain/Disc Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Back Injury/Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations/Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Arm or Leg Numbness/Muscle Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or Severe Headache Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack(s) Date(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty/Coronary Stents(s) Date(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis/Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery Date(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestinal Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Reflux Esophagitis/GERD
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath Walking	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath at Rest	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/Defibrillator Last Checked: _____	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Cold in Past 2 Weeks	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease/Porphyrria
<input type="checkbox"/>	<input type="checkbox"/>	Fever in Past 48 Hours	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Smoked Tobacco in the Past Year? Packs per Day: _____	<input type="checkbox"/>	<input type="checkbox"/>	Prednisone/Steroid Use Last Taken? _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Bronchitis/Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Recent Abnormal Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Weight Reduction Meds
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia in past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Consumption Drinks per day: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis/Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	You/Family: Post=Op Nausea/Vomiting in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	You/Family: Other Problem with Anesthesia
<input type="checkbox"/>	<input type="checkbox"/>	CPAP Use regularly? _____	<input type="checkbox"/>	<input type="checkbox"/>	You/Family: Bleeding Problem(s)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Is there any chance you could be pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Chipped, Cracked or Loose Teeth
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Crowns/Veneers/Partial/Full Denture
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Herbal products in last month?
<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Other illness not mentioned above?

Previous Surgeries: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

NPO > 8 hrs     Vital Signs Stable    Lungs: CTA-B   
 ASA Physical Status: I II III IV V E    Heart: RRR   
 Anesthesia Plan: \_\_\_\_\_    MP Class: 1 2 3 4

**Labs:**

  
  
  

- Operative Procedure and Site Verified
- Risks Discussed and Questions Answered
- Consent Obtained

**Discharge Note** Time: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_

Resp. \_\_\_\_\_ O2 Sat. \_\_\_\_\_ Temp: \_\_\_\_\_ Blood Glucose \_\_\_\_\_

Criteria-Based Discharge:  D/C Criteria Met, Aldrete Score > 8

Direct Discharge:  Patient Evaluated by MDA, ready for Discharge

CRNA / MDA Signature

Date / Time