PRE/POST ANESTHESIA ASSESSMENT FORM

Age: _____ **Wt:** _____ **Ht:** _____ **NPO:** _____

Drug Allergies: _____

Drugs/Dosage: _____

Family/Personal History of anesthesia problems:
None **Problems Noted:** _____

Past anesthesia/surgical history: _____

Past Medical History / Review of Systems:

CV:	CAD MI	Stents	Angina	CHF	Arrhythmias	HTN	Murmur
	Pacer/AICD	Dyslipidemia					
PULM:	Asthma	COPD	URI	Bronchitis	CPAP	Apnea	Tobacco ____Pkg ____yr
Renal:	Dialysis	Renal Insufficiency	Renal Failure	Kidney Stones	BPH		
NEURO:	TIA/CVA	Chronic Pain	Seizures	Neuro Deficit	Psychiatric History	Anxiety	Depression
GI/Hepatic:	Jaundice	Hepatitis	Hiatal Hernia	Peptic Ulcer	GERD	Dysphagia	Abdominal Pain
	Bleeding	IBS	Crohn's/UC	HX Colon Ca	Hx Polyps	Diverticuli	Screening
General:	Anemia	Diabetes	Arthritis	Dental Problems	Obesity	Thyroid Disease	ETOH ___amt/____freq Drug Use

Physical: Mental Status: _____ Heart: _____

Lungs: _____ Airway: MP 1 2 3 4

Comments: _____

_____

_____

☐ Anesthesia plan, risks, alternatives, benefits discussed with patient and/or family

☐ Patient appears to understand

☐ Patient cleared for Anesthesia in ASC setting

Anesthesia Plan: **MAC** **GA**

ASA Classification: **I** **II** **III**

Anesthesiologist Signature: _____ **Date:** _____ **Time:** _____

Reviewed by: _____ **Date:** _____ **Time:** _____
(CRNA Signature)

POST ANESTHESIA NOTE

Level of Consciousness: **Awake** **Arousable** **Somnolent**

Cardiopulmonary Status: **WNL** **Other:** _____

☐ **Nausea / Vomiting**

☐ **No apparent complications**

☐ **Adequate pain management**

☐ **Hydration is adequate or** _____

Need for Follow-up Care: **None** **Care as follows:** _____