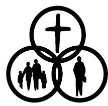

College Park Family Care Center P.A.

PRE-ANESTHESIA EVALUATION

Today's date: ____________

Name:		PCP:	Endoscopy Provider:
DOB:	Age:	Weight:	Height:
List any drug allergies you have:			

Please review the medication list and check the appropriate box:
Medication list is correct ☐ Corrections were made on the medication list ☐

Are you allergic to latex products? ☐ no ☐ yes	Are you allergic to eggs or soy?	☐ no	☐ yes
Have you ever been instructed to take antibiotics before a procedure due to do heart conditions, heart valve, joint replacement, etc.?		☐ no	☐ yes

Anesthesia history			
1.	Have you ever been put to sleep or had IV sedation? If yes, please list below.	☐ no	☐ yes
2.	Have you or your blood relatives had difficulties with anesthesia?	☐ no	☐ yes
3.	Have you ever had a reaction to lidocaine (numbing medication)?	☐ no	☐ yes
Health status			
4.	Have you had a heart attack within the last 6 months?	☐ no	☐ yes
5.	Do you have a pacemaker?	☐ no	☐ yes
6.	Any history of other heart problems? (i.e., skipped beats, chest pain, valve disease, high blood pressure)	☐ no	☐ yes
7.	Are you on any blood thinning medication? (Coumadin, Plavix, Aspirin)	☐ no	☐ yes
8.	Are you on any anti-inflammatory medications? (Aleve, Ibuprofen, Advil, etc.)	☐ no	☐ yes
9.	Do you have lung problems? (Asthma, Emphysema, difficulty breathing)	☐ no	☐ yes
10.	Do you have a history of fainting or passing out? (i.e., Syncope)	☐ no	☐ yes
11.	Do you have a history of sleep apnea?	☐ no	☐ yes
12.	Do you have a history of Diabetes?	☐ no	☐ yes
13.	Do you have a history of a blood disorder or anemia?	☐ no	☐ yes
14.	Have you received a blood transfusion?	☐ no	☐ yes
15.	Do you have a history of Hepatitis or HIV?	☐ no	☐ yes
16.	Do you have a history of liver, kidney, or thyroid disease?	☐ no	☐ yes
17.	Do you have a hiatal hernia?	☐ no	☐ yes
18.	Do you have ulcers or other stomach disorders?	☐ no	☐ yes
19.	Do you have back or neck pain?	☐ no	☐ yes
20.	Do you have numbness, weakness, or paralysis of your extremities?	☐ no	☐ yes
21.	Do you have a history of seizures?	☐ no	☐ yes
22.	Do you take any prescription medications for pain or anxiety?	☐ no	☐ yes
23.	Do you take or have you taken recreational drugs within the last year?	☐ no	☐ yes
24.	Do you drink any alcoholic beverages? #_______per day	☐ no	☐ yes
25.	Do you currently smoke? #________per day	☐ no	☐ yes
26.	Do you have any oral piercing, such as studs or rings in your tongue or lip?	☐ no	☐ yes
27.	Do you have loose, chipped, false teeth or bridgework?	☐ no	☐ yes
28.	Do you wear contacts?	☐ no	☐ yes
29.	(Women only) Are you pregnant? If yes, due date: ______	☐ no	☐ yes
30.	(Women only) Have you had a period within the last 12 months? If yes, when? _______	☐ no	☐ yes
31.	(Men only) Have you taken Viagra, Cialis, or other erectile dysfunction medications?	☐ no	☐ yes

If you answered "yes" to questions 1-31, please explain below

#	Explanation	#	Explanation

______________________________ Physician Signature

______________________________ Date

Questionnaire valid for 6 months

0212ss