PATIENT HISTORY/NURSING ASSESSMENT

ADMISSION FORM				
Age	Sex	Wt	Ht	Possible pregnancy? ❑ No ❑ Yes Last menstrual period:

Scheduled operation:

Pain scale 0-10:

ALLERGIES/SENSITIVITIES

Drug/Iodine/Food/Latex/Sulfites/Other Reaction

MEDICATIONS HISTORY

Medications/Dosage/Frequency Last taken

Have you had any previous anesthetics? ❑ NO ❑ YES

Personal or family history of anesthesia problems? ❑ NO ❑ YES

Previous hospitalization? ❑ NO ❑ YES

Previous surgery? ❑ NO ❑ YES

LUNGS DISEASES			
Asthma/ Wheezing	NO	YES	
Emphysema/COPD	NO	YES	
Chronic cough	NO	YES	
Pneumonia	NO	YES	
Tuberculosis/ + TB test	NO	YES	
Recent TB exposure	NO	YES	
Valley fever	NO	YES	
Smoker?	NO	YES	# packs per day:
Recent cold/flu	NO	YES	

HEART/CIRCULATION DISEASES			
High blood pressure	NO	YES	
Heart murmur/MVP	NO	YES	with antibiotics?
Heart attack	NO	YES	
Chest pain/ angina	NO	YES	
Irregular heart beat	NO	YES	
Short of breath/CHF	NO	YES	
Rheumatic fever	NO	YES	
Pain legs	NO	YES	
Blood clots	NO	YES	

Patient Signature

Answer yes or no to each of these conditions

Dentures, bridges, loose teeth, or partial?	NO	YES
Glasses/Contact lenses or hearing aid?	NO	YES
Artificial objects in body?	NO	YES

SOCIAL HISTORY			
Alcohol	NO	YES	Amount
Drug use	NO	YES	Amount

IMMUNE SYSTEMS			
Recent steroid use?	NO	YES	
Leukemia/Lymphoma/ Cancer	NO	YES	
Radiation therapy	NO	YES	When
Chemotheraphy	NO	YES	When
Immune disorders	NO	YES	
Weight loss > 10 lbs	NO	YES	

BLOOD/LIVER/DIGESTIVE SYSTEMS			
Anemia	NO	YES	
Bleeding tendency/Disorders	NO	YES	
Hepatitis/Jaundice	NO	YES	
Difficulty swallowing	NO	YES	
Colon problems	NO	YES	
Stomach problems	NO	YES	
Frequent heart burn	NO	YES	

MUSCULOSKELETAL/ NEUROLOGICAL			
Convulsion/Seizures	NO	YES	
Blackouts/Fainting	NO	YES	
Mental Health problems	NO	YES	
Stroke	NO	YES	
Nerve/Muscle problems	NO	YES	
Limited joint movement	NO	YES	
Back injury/Pain	NO	YES	
Headache/Migraine	NO	YES	

ENDOCRINE/ URINARY DISEASES			
Diabetes	NO	YES	
Thyroid disorder	NO	YES	
Kidney problems	NO	YES	

Last time I had anything to eat or drink:

Nurse's comment:

_____ _____

Nurse Signature **Date**

Anesthesia plan: **GA** **SAB** **EPI**
IV REG **MAC**

ASA class: **1** **2** **3** **4** **E**

_____ _____

Anesthesia MD Signature: **Date**

NAME: _____
DOB: _____