BRAZORIA COUNTY SURGERY CENTER

PRE-OP INTERVIEW

☐ Phone ☐ In Person

PATIENT LABEL

General Info

Name verified: ☐ Yes ☐ No

Patient ID Method: ☐ Verbal ☐ DOB ☐ MR# ☐ Other:_____

PCP: _____

Anesthesia Type: ☐ General ☐ MAC/TIVA ☐ IVCS ☐ Local ☐ Other

Stated Procedures: _____

Translator needed: ☐ No ☐ Yes:

EKG/Labs/Films (last 6 mo?) CXR in the past year? ☐ Yes ☐ No

EKG: ☐ Yes ☐ No Lab Work: ☐ Yes ☐ No Films: ☐ Yes ☐ No

Urine Pregnancy Test: ☐ N/A ☐ Negative ☐ Positive DATE: _____

Other Mandatory Items/Tests: _____

Are you treated on a regular basis by a specialist? (Cardiologist, Neurologist, etc)?

☐ Yes ☐ No

Assessment

Ht	Wt	LMP:

Do You Smoke? ☐ Yes ☐ No ____ Pkg/Day Ever Smoked? ☐ Yes ☐ No

Use Alcohol? ☐ Yes ☐ No Daily ☐ Socially ☐

Hx of rxn to anesthesia? ☐ Yes ☐ No If Yes:_____

HX of MH? ☐ Yes ☐ No Muscle biopsy done? ☐ Yes ☐ No

Hx of MH in family? If yes, who?

ALLERGIES TO MEDICATIONS

Name:	Reaction:

Are you allergic to latex? ☐ Yes ☐ No

MEDICATIONS YOU ARE CURRENTLY TAKING:

Name:	Dose:	Frequency:	Last Taken: Ask day of surgery

PREVIOUS SURGERIES

Surgery:	Date:

HAVE YOU HAD:

Heart Trouble/Chest pains	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Lung Disease/Difficulty Breathing/Productive Cough	☐ Yes	☐ No	Blood Vessel Disease (phlebitis, etc)	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Hepatitis or Mononucleosis	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
PUD / Hiatal Hernia / GERD	☐ Yes	☐ No	Wear Dentures/Loose teeth/Caps/Bridges	☐ Yes	☐ No
Back Trouble	☐ Yes	☐ No	Wear Glasses/Contacts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Wear Prosthesis	☐ Yes	☐ No
Abnormal Bleeding Tendencies	☐ Yes	☐ No	Wear Hearing Aids	☐ Yes	☐ No
Anticoagulant Therapy (blood thinners)	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Blood Disease (anemia, etc.)	☐ Yes	☐ No	ADD	☐ Yes	☐ No
Kidney Disease/Difficulty with Urination	☐ Yes	☐ No	Recent Cold, Flu, Infections	☐ Yes	☐ No
Fracture of Facial Bones	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Fracture of Neck or Back	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Muscle Weakness	☐ Yes	☐ No	Have you ever felt threatened verbally/emotionally/physically?	☐ Yes	☐ No
Paralysis/Numbness/Tingling	☐ Yes	☐ No	Other:_____		

You must be accompanied by a responsible adult for 24 hours after surgery. Who will drive you home? _____ Who will stay with you? _____

Pre-OP instructions reviewed with patient. ☐ Yes Copy given to patient. ☐ Yes

Nurse's Signature_____ Date:_____ Time_____

PRE-ANESTHESIA EVALUATION:

Airway: _____

Cardiovascular: _____

Chest: _____

Other: _____

Vital Signs: HR: BP: RR: O2 Sat:

ASA: ☐ 1 ☐ 2 ☐ 3

Anesthetic Proposed: ☐ Local ☐ MAC/TIVA ☐ General ☐ Spinal ☐ Standby ☐ Regional

I have explained Anesthesia risks, benefits and alternatives to care. ☐ Yes

Anesthesiologist *Date* *Time*

POST-ANESTHESIA EVALUATION:

☐ Condition satisfactory ☐ Awake ☐ Stable

☐ May discharge home when all criteria met

☐ Transfer to hospital. Explain:_____

☐ QI notified

Comments: _____

Anesthesiologist *Date* *Time*