SUNBELT ANESTHESIA SERVICES

PATIENT INFORMATION REPORT

- **Please press hard when completing this form. You are making 5 copies.**
- **If you then have questions, or do not understand an item, leave the section blank.**

AGE:	HEIGHT: ________ft. ________ in.	WEIGHT: _________ lbs.	PATIENT IDENTIFICATION

TODAY'S DATE:	DATE OF SURGERY:	ACT CLINIC DATE:	HOME PH: ( )	WORK PH: ( )

PLEASE PLACE AN "X" IN THE BOX THAT APPLIES FOR EACH QUESTION BELOW		YES	NO
1. Have you had an EKG in the last 90 days?			
2. Are you: a. 50 years of age or older?			
b. If yes, are you also 70 years of age or older?			
3. Do you take any of the following medications?			
a. Diuretics ("Water Pills")			
b. Anticoagulants ("Blood Thinners")			
c. Insulin			
d. Digitalis (Digoxin, Lanoxin)			
4. Do you have or have you had any of the following heart related conditions?	a. Heart Disease?		
	b. Family History of Heart Disease?		
	c. Heart Attack within the last 6 months?		
	d. Angina (Chest Pain)		
	e. Irregular Heartbeat		
	f. Heart Failure		
	g. Hypertension		
5. Do you have or have you ever had any of the following?	a. Symptomatic Rheumatoid Arthritis		
	b. Hiatal Hernia or Reflux (Heart Burn)		
	c. Kidney Disease		
	d. Liver Disease		
	e. Blood Disease		
	f. Diabetes		
6a. Do you get short of breath when you lie flat?			
6b. Are you currently on oxygen treatment?			
6c. Do you have a chronic cough, and/or a cough that produces any discharge or fluid?			
6d. Do you smoke?			
6e. Do you have asthma (or wheezing) requiring a hospital visit within the last 6 months?			
6f. Have you had a chest x-ray in the last 6 months?			
7. *If you answered yes to any of 3, 4, & 5 above:* a) Do any of these problems significantly limit your daily activities?			
b) Do you feel tightness or chest pressure with activity?			
c) Are you seeing a cardiologist or another physician for any of these medical problems? *(Please continue in next column)*			

PLEASE PLACE AN "X" IN THE BOX THAT APPLIES FOR EACH QUESTION BELOW	YES	NO
7. *(Continued)* d) If yes, complete below: Date of last visit: / Physician's Name: / Phone No. ( )		
e) Have you had any changes in your symptoms since that last physician visit?		
f) Do you have a pacemaker?		
g) If yes, has it been evaluated in the past 6 months?		
8a. Have you ever had any operations?		
8b. Were any of the operations performed at this facility?		
8c. Have you ever had a problem with any anesthesia other than nausea?		
8d. Has any blood member of your family had problems with anesthesia?		
8e. If yes, who:_______________________		
8f. Do you have any allergies to medications?		

Medications:	Reactions:

	YES	NO
8g. Do you have a Latex sensitivity?		

9. Are you currently taking any medications? If yes, list below.

Medications:	Dose:

	YES	NO
10. If female, is it possible that you could be pregnant?		

11. Please list date of last menstrual period:

PATIENT / PARENT / GUARDIAN SIGNATURE

For Physician's Use Only:

☐ Request assistance by Anesthesia in post-operative pain management

Patient will be seen for Anesthesia consult if indicated by form; or if other rationale provided by physician as follows:

MD SIGNATURE | DATE | COMPUTER ID #

SUNBELT ANESTHESIA SERVICES

PREOPERATIVE ASSESSMENT CHECKLIST

Please order the test(s) and/or studies as indicated below:

AGE:	HEIGHT: ________ft. ________ in.	WEIGHT: _________ lbs.	PATIENT IDENTIFICATION

TODAY'S DATE:	DATE OF SURGERY:	ACT CLINIC DATE:	HOME PH: ( )	WORK PH: ( )

Test	
2a. ECG	
2b.Preoperative Anesthesia Clinic visit, ECG	
3a. Electrolytes	
3b. PT/PTT	
3c. ECG, Electrolytes	
3d. ECG/CXR	
4a. ECG & Preoperative Anesthesia Clinic Visit	
4c. ECG & Preoperative Anesthesia Clinic Visit	
4d. ECG & Preoperative Anesthesia Clinic Visit	
4e. ECG & Preoperative Anesthesia Clinic Visit	
4f. ECG & Preoperative Anesthesia Clinic Visit	
5a. Cervical Spine X-Ray's & Preop. Anesthesia Clinic Visit	
5c. Elec., Cret., BUN, CBC	
5d. SGOT/ALK, PT/PTT	
5e. PT/PTT, PLT, CBC	
5f. ECG & Preoperative Anesthesia Clinic Visit	
6a. CXR, ECG; Preoperative Anesthesia Clinic Visit	
6b. CXR, ECG, ABG; Preoperataive Anesthesia Clinic Visit	
6c. CXR; Preoperative Anesthesia Clinic Visit	
7a. Preoperative Anesthesia Clinic Visit	
7b. ECG & Preoperative Anesthesia Clinic Visit	
7e. Preoperative Anesthesia Clinic Visit	
7f. Preoperative Anesthesia Clinic Visit and Pacemaker Evaluation	
8c. Preoperative Anesthesia Clinic Visit	
10. Pregnancy Test	

In addition, please order the test(s) indicated below:

☐ Request assistance by Anesthesia in post-operative pain management

Patient will be seen for Anesthesia consult if indicated by form; or if other rationale provided by physician as follows:

MD SIGNATURE ________ DATE ________ COMPUTER ID # ________