PRE OP SURGICAL AND ANESTHESIA CHECKLIST (1)

MENTAL STATUS (Circle all that apply)

Oriented Confused Angry Depressed Forgetful Nervous Mentally Challanged

Ht___________ Wt__________ Sex_______ Allergies: Drugs, Latex, Food, Other____________________

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Power of Attorney: () Yes () No Living Will: () Yes () No Interpreter Needed () Yes () No
Name: ____________________

LMP____________________ Pregnant () Yes () No () N/A

History of Disease: Do you have or ever had any of the following? If yes-circle

LUNG: __Bronchitis __Emphysema __Asthma __Chronic Cough __Sinusitis __Pneumonia __SOB __COPD __Sleep Apnea

VASCULAR: __HBP __Heart Attack __Heart Disease __Chest Pain __Murmur __Stroke __Blood Clots __Sickle Cell __Rheumatic fever

ENDOCRINE: __Diabetes __Thyroid Problems __Fainting __Liver Problems __Jaundice __Hepatitis/Cirrhosis

NEUROMUSCULAR: __Convulsions __Epilepsy __Muscle weakness __Fibromyalgia

URINARY: __Kidney Failure __Bladder Problems __Kidney Stones

GASTRIC: __Stomach __Hiatal Hernia __Acid Reflux __Heart Burn __Bowel __Polyps/Diverticulosis __Esophageal Stricture __Bleed. Ulcer

OTHER: __Mono __TB __Cancer __Glaucoma __Night sweats __Arthritis __Macular Degeneration __High Cholesterol __Anxiety __Depression

Comment on any underlying condition or problems we should know about:____________________

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MEDICATIONS: ____ Medication Inventory ____ No Rx

PRIOR SURGERIES: ____

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