

Please complete both side of this form at home and give to the receptionist when you arrive for your Pre-Op appointment.

PRE-ANESTHESIA EVALUATION
Paces Plastic Surgery and Recovery Center

Please complete all questions, front & back, and sign

_____ M F _____ yrs _____/_____/_____ '_____' _____ lbs. _____
Patient Name sex age date of birth height weight occupation

Is there any chance that you are now pregnant? _____ If you menstruate, what was the first day of your last menstrual period? _____

List ALL Allergies

Drugs, Tape, Iodine, Latex, Etc.	Your reaction to them	Drugs, Tape, Iodine, Latex, Etc.	Your reaction to them
1.		3.	
2.		4.	

List ALL Prescription Medications

Medication	Reason you take this	Dosage	Medication	Reason you take this	Dosage
1.			4.		
2.			5.		
3.			6.		

List all over-the-counter medicines, natural or herbal products you take:

If you have had anesthesia before, list those surgeries and approximate dates

Year	Operation	Year	Operation	Year	Operation

Did you experience nausea with anesthesia? _____ Other problems related to anesthesia? _____

Has anyone directly related to you had a high fever or breathing problems related to anesthesia? _____

Do you experience motion sickness? _____ (This can increase your risk for nausea after surgery.)

CIRCLE ALL THAT APPLY IF YOU HAVE OR HAVE HAD THE FOLLOWING:

yes no... Have you or do you now smoke? _____ packs per day for _____ years. When did you quit? _____

yes no... Do you drink alcoholic beverages? Approximately how many drinks/ beers in a week? _____

yes no... Do you use "recreational drugs or substances"? What & how often? _____

- yes no...Heart condition: angina, chest pain, previous heart attack, irregular heart beat, high blood pressure, murmur, heart failure, other _____
- yes no ...Heart treatment procedures, pacemaker, internal defibrillator, stent placement, or other heart operations or heart tests _____
- yes no ...Have you had any breathing problems: sleep apnea, asthma, emphysema, chronic chest colds, recent pneumonia bronchitis, flu, sinus infection or recent cold, or do you cough most or every day? _____
- yes no... Have you had any treatment for your lungs or to improve your breathing? _____
- yes no... Have you had major dental work: caps, veneers, crowns, bridges, dentures? _____
- yes no... Do you have any loose, chipped, or fragile teeth? **NOTE: Dental injury is a risk in spite of every precaution.**
- yes no... Did you have any stomach, digestion, gallbladder, or intestinal problems or related surgery? _____
- yes no... Have you any liver problems, or history of hepatitis? When? _____ Type? _____
- yes no... Have you had any kidney, prostate or bladder problems, or related treatment procedures? _____
- yes no... Have you had any history of thyroid or goiter problems? How do you treat this? _____
- yes no... Have diabetes? Treated with diet, medications or insulin? _____
- yes no... Have you had any brain disorders, stroke, seizure, migraines, vascular disorder, other? _____
- yes no... Have you had any nerve or muscle problem? Explain _____
- yes no... Has a doctor told you that you have arthritis, spine, bone, or joint problems? Explain _____
- _____
- yes no... Have you needed medical treatment for your mood or feelings? _____
- yes no... Has a doctor told you that you have a blood condition, excessive bleeding, easy bruising, blood clots, anemia, sickle cell disease or trait? Other? _____
- yes no... Have you had cancer? _____
- yes no... Has a doctor told you that you have an infectious disease? Hepatitis, HIV, AIDS?
- yes no... Have you taken any **oral** Cortisone, Prednisone, or other steroid medications in the past 6 months?
- yes no... Do you have any other medical conditions not already listed above? _____

Activities: (**circle all that apply**) Are you physically able to: do light physical work OR heavy physical work

Please list any concerns you have about anesthesia: _____

I ACKNOWLEDGE THAT I AM NOT TAKING PRESCRIPTION DIET PILLS (PHENTERMINE). THESE CAN CAUSE SEVERE COMPLICATIONS WITH ANESTHESIA. I MUST BE OFF THEM FOR AT LEAST 2 WEEKS PRIOR TO SURGERY.

↑ Please initial ↑

Signature of person completing this form

_____/_____/_____
date