

Physicians Surgery Center Preoperative Evaluation

Sex (Circle): M F Age: _____ Height: _____ Weight: _____

Proposed Surgical Procedure: _____

Allergies: _____

Medications: _____

Previous Surgery: _____

Anesthesia Problems or Family History of Anesthesia Problems: _____

History (Check Yes or No)

General: _____

Glaucoma Yes No
Serious Illness Yes No
Dentures Yes No
Bleeding Problems Yes No
Hearing Loss Yes No
Alcohol/Drug Abuse Yes No
Smoke Yes ___ Packs No
Anemia Yes No
Arthritis Yes No

Cardiovascular: _____

Heart Attack Yes No
High Blood Pressure Yes No
Angina Yes No
Congestive Heart Failure Yes No
Poor Circulation Yes No
Coronary Artery Disease Yes No
Pacemaker Yes No
Defibrillator Yes No

Respiration: _____

Pneumonia Yes No
Asthma Yes No
Emphysema Yes No
Recent Upper Resp. Infection Yes No
Shortness of Breath Yes No
Tuberculosis Yes No

GI: _____

Liver Disease Yes No
Hepatitis Yes No
 No
Stomach Problems Yes No

GU: _____

Frequent Kidney Infections Yes No
Renal Failure Yes No
Kidney Disease Yes No
Claustrophobia Yes No
Sleep Apnea/CPAP Yes No

Metabolic: _____

Diabetes Yes No
Age of Onset: _____
Rx Oral: _____
Insulin: _____
Control: _____

Neurology:

Epilepsy/Seizures Yes No
Frequent Headaches Yes No
Difficulty Walking Yes No
Dizziness Yes No
Back/Neck Disorder Yes No
Stroke Yes No

Cancer History: _____

Current Medical Doctor: _____

Date of Last Physical Exam: _____

Nurse Signature: _____ Date: _____