Name: ______________________________

Height:_________________________ **Allergies:** ____ **LATEX ALLERGY?** **YES** **NO**

Weight:_________________________ **Reactions:** ____

Source (Please circle all that apply): Patient Family member Provided med list H & P Physician Nurse Other

PLEASE LIST ALL MEDICATIONS BELOW
(including herbal supplements, pumps, patches and over the counter medications)

Medication (Generic or Brand Name)	**Dose** (*How Much?*)	**Frequency** (*When* do you take it?)	**Route** (*How* do you take it?)	This Section To Be Completed By Nursing Staff		
				Take Day of Surgery?	**Date and Time Last Taken**	**Continue on Discharge?**
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
				Yes No		Yes No Call Physician
Prescriptions given at discharge:						

Preop Nurse's Signature & Date: ____

Verified DOS by:

____
(DOS Pre-Op Nurse Signature)

PACU Nurse's Signature: ____

I understand and have received a copy of this medication list.

Patient's/Family Signature: ____

Patient Sticker

Name: ______________________

TAMPA OUTPATIENT SURGICAL FACILITY
ANESTHESIA EVALUATION

Surgical Procedure: ________________________________ **Age:** __________ **Ht.:** __________ **Wt.:** __________

PLACE AN "X" IN THE PROPER COLUMN:		YES	NO	DON'T KNOW
1. DO YOU HAVE TO TAKE ANTIBIOTICS TO PROTECT YOUR HEART BEFORE SURGERY?				
2. DO YOU SMOKE? PPD _______ YRS. ________ QUIT ________				
3. DO YOU USE RECREATIONAL DRUGS?				
4. DO YOU DRINK ALCOHOL?				
5. DO YOU HAVE ANY LOOSE, CAPPED, OR FALSE TEETH?				
6. DO YOU WEAR CONTACT LENSES?				
7. HAVE YOU EVER HAD ANY HEART PROBLEMS?	HIGH BLOOD PRESSURE			
	LOW BLOOD PRESSURE			
	RHEUMATIC FEVER			
	HEART ATTACK			
	HEART MURMUR			
	CHEST PAIN/ANGINA			
	IRREGULAR HEART BEAT			
	CONGESTIVE HEART FAILURE			
8. HAVE YOU EVER HAD ANY LUNG PROBLEMS?	ASTHMA/WHEEZING			
	BRONCHITIS OR PNEUMONIA			
	SHORTNESS OF BREATH			
	(CPAP) CONTINUOUS POSITIVE AIRWAY MACHINE / (O2) OXYGEN MACHINE			
	SLEEP APNEA			
9. HAVE YOU EVER HAD ANY URINARY PROBLEMS?	URINARY INFECTIONS			
	KIDNEY STONES			
10. DO YOU HAVE ANY INFECTIOUS DISEASES?				

HEPATITIS HIV TB MRSA (IF SO, PLEASE CIRLCE)

PLACE AN "X" IN THE PROPER COLUMN:		YES	NO	DON'T KNOW
11. HAVE YOU EVER HAD ANY DIGESTIVE TRACT PROBLEMS?	ULCERS/HIATAL HERNIA			
	ACID REFLUX			
12. HAVE YOU EVER HAD ANY MUSCLE OR JOINT PROBLEMS?	ARTHRITIS			
	BROKEN BONES			
	LIMITED JOINT MOVEMENT			
13. HAVE YOU EVER HAD ANY METABOLIC PROBLEMS?	DIABETES			
	THYROID DISEASE			
14. HAVE YOU EVER HAD A (TIA) TRANSIENT ISCHEMIC ATTACK OR (CVA) CEREBROVASCULAR ACCIDENT?				
HEAD INJURY, HEADACHES, NUMBNESS OR TINGLING IN EXTREMITIES, CONVULSIONS/EPILEPSY?				
15. HAVE YOU OR ANY FAMILY MEMBERS EVER HAD ANY PROBLEM WITH AN ANESTHETIC?				
MALIGNANT HYPERTHERMIA?				
16. ARE YOU PREGNANT?				
HAD A HYSTERECTOMY OR TUBAL LIGATION?				

17. DO YOU HAVE ANY HISTORY OF ANY CANCERS? PLEASE LIST

18. HAVE YOU EVER HAD ANY SURGERIES? PLEASE LIST

19. DO YOU HAVE ANY ALLERGIES? PLEASE LIST

OFFICE USE ONLY

PREGNANCY TEST ______________________________

DATE: ______________________ BY: ____________________________

____

ACCU CHECK: ______________ MG/DL (NORMAL RANGE 70 – 110 MG/Dl)

DATE: ______________________ BY: ____________________________

OFFICE USE ONLY

PHYSICAL EXAMINATION / DOS ASA# 1 2 3 4 5

AIRWAY: DOS 1: ________ DOS 2: ☐ No Change / ______ DOS 3: ☐ No Change / ______

HEART: DOS 1: ________ DOS 2: ☐ No Change / ______ DOS 3: ☐ No Change / ______

LUNGS: DOS 1: ________ DOS 2: ☐ No Change / ______ DOS 3: ☐ No Change / ______

☐ LABS/EKG/CXR REVIEWED NPO ____________ HRS.

PROPOSED ANESTHESIA ____

☐ PT REQUESTS ANESTHETIC SEDATION (MAC/GETA)

☐ DR REQUESTS ANESTHESIA PRESENCE 2[0] TO MEDICAL STATUS

☐ PT & SURGEON REQUESTS POST-OP PAIN MANAGMENT

☐ ANESTHESIA HAS REVIEWED EVALUATION WITH PATIENT & ADDRESSED CONCERNS

____ ______________________

ANESTHESIOLOGIST'S SIGNATURE: DATE/TIME

PAIN MANAGEMENT / HEALTH STATUS UNCHANGED

DATE	SIGNATURE
1.____________________	______________________________
2.____________________	______________________________
3.____________________	______________________________

PATIENT STICKER

Name: ______________________

OFFICE USE ONLY

Pre-op Teaching and Instructions

Date of Interview: ________________________ Type of Interview: _____ Phone _____ Pre-Op Visit _____ Day of Surgery

Labs ordered: Per Criteria / Physician / N/A Date / Location of labs to be drawn: ____________________________________

Medical / Cardiac Clearance: Yes / No Name of Physician __________________________ Phone / Fax No: ____________________

Primary Care Physician: ___________________________ Phone No: ________________ Bring paperwork from surgeon: ______

DOS Arrival Time: ______________________ Ride: ____ NPO Time: _____________

Clothing/makeup suggestions: ___ Jewelry left home: ___ Directions to facility: ___ Person Interviewed: Patient / Other: ___________

Comments: ____

Interview & Pre-op teaching by: _________________________________ **Interpreter (if applicable):** ________________________

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Interview & Pre-op teaching by: _________________________________ **Interpreter (if applicable):** ________________________

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Comments: ____

Interview & Pre-op teaching by: _________________________________ **Interpreter (if applicable):** ________________________