UNIVERSITY Pain Clinic

PATIENT PRE-OPERATIVE EVALUATION FORM

Name: _____ Age: _____ Date: _____

Procedure: _____ Date: _____

_____ Male _____Female Height: _____ Weight: _____

Allergies (medication, latex, food): _____ None _____ Yes, please list all: _____

_____

Past Surgical History: _____

_____

_____

_____

_____

Current Medications (include herbal and over-the-counter):

_____

_____

_____

_____

Medical History:

Please check either Yes or No. If there is more than one choice, circle the one that pertains. Do you have or have you had in the past:

	Yes	No		Yes	No
Problems with anesthesia: Patient Family			Hiatal hernia/ulcers/gastritis/reflex		
Bleeding/clotting disorder			Diabetes		
Blood thinner usage			Seizures/epilepsy/blackouts		
High blood pressure/stroke			Arthritis/neck problems		
Cardiac (heart) problems:			Kidney/liver disease		
Chest pain/angina/pacemaker			Bladder/prostate problems		
Shortness of breath/cough/pneumonia			Anemia/sickle cell disease		
Bronchitis/emphysema/asthma			Thyroid disease/goiter		
Recent cold/sore throat			History of street/social drug use		
Do you currently smoke?			Drink alcohol? - How much		
Special weight loss diet/meds			Cancer		
Glaucoma/other visual problems			Could you be pregnant?		
Recent exposure to communicable disease			Last menstrual period?		
TB/HIV/hepatitis/other			Car, air, sea or motion sickness		
Aspirin/anti-inflammatory use					

Other: _____

Do Not Fill Past This Point. Internal Use Only

Review/Comment: _____

Anesthesia plan/risks discussed with patient/guardian; patient understands/accepts: _____ Yes

Signature: _____ Date: _____