East Atlanta Eye Surgery Center
550 Professional Drive
Lawrenceville GA, 30046

PRE-ASSESSMENT ANESTHESIA QUESTIONNAIRE

SPECIAL QUESTIONS

❒ Yes ❒ No Do you have a pacemaker? ❒ Yes ❒ No Are you dependent?

❒ Yes ❒ No Do you use an implanted defibrillator?

❒ Yes ❒ No Do you use oxygen at home? ❒ Yes ❒ No Are you dependent on oxygen?

❒ Yes ❒ No Have you had a heart attack within the last 6 months? Date: ____/____/____

❒ Yes ❒ No Have you had a stroke or mini stroke (TIA) within the last 6 months?

Date: ____/____/____

❒ Yes ❒ No Are you on dialysis? ❒ Hemodialysis ❒ Peritoneal dialysis

Days for Dialysis: ❒ Monday ❒ Tuesday ❒ Wednesday ❒ Thursday ❒ Friday ❒ Saturday

NOTE: DIALYSIS MUST BE DONE 1 DAY PRIOR TO SURGERY. Exception: For Monday surgery, dialysis on Saturday.

Patient Demographics

SURGERY DATE: _____/_____/_____

Patient Name:	Preferred Name:	
Day Phone:	Cell Phone:	Evening Phone:
Date of Birth:	Sex: ❒ Male ❒ Female	HEIGHT: ____ ft. ____ in. WEIGHT: _____
Emergency Contact Name:		Phone Number:

Name of responsible adult driving patient home from surgery:

Surgery History

Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

Anesthesia

Have you or anyone in your family had an unusual reaction to anesthesia, such as
❒ high temperature ❒ difficulty waking up ❒ nausea and/or vomiting? ❒ Yes ❒ No

If Yes, please explain:

Implants

Do you have any implants or prostheses? ❒ Yes ❒ No Type:

Family History:

Has any member of your family had any of the following? **If Yes, list family member.**

1. Heart / Cardiovascular Disease / Blood Disorders ❒ Yes ❒ No
2. Hypertension ❒ Yes ❒ No
3. Diabetes ❒ Yes ❒ No
4. Stroke ❒ Yes ❒ No
5. Cancer ❒ Yes ❒ No
6. Other: ❒ Yes ❒ No

Medication List:	Allergies & Reactions:
1	1.
2	2.
3	3.
4	4.
5	5.
6	6.
7	7.
8	8.
9	9.
10	10.

Question	Yes	No	Comments / Explanation
Cardiovascular			
Have you ever had angina / chest pain / heart attack?			Current or past?
High or Low blood pressure, Rheumatic fever,			
Congestive heart failure? Mitral valve prolapse?			
❒ Heart surgery ❒ Stent ❒ Catheterization ?			**Date: ____/____/____**
❒ Palpitations ❒ Irregular heart beat?			
Diabetes			
Controlled by ❒ Diet ❒ Oral Meds ❒ Insulin ❒ Insulin Pump			
Pulmonary			
Asthma, restrictive airway disease, bronchitis, COPD, smoker?			_____packs per day:
Sleep apnea, CPAP/BiPap machine?			
History of or recent exposure to TB? Communicable disease?			
Impairments / Disabilities			
Hearing, Vision, Mobility? In Wheelchair? Able to stand/pivot?			
Dental			
Any dentures/bridges, caps, crowns, chipped or loose teeth?			
Skin			
Any burns, rashes, bruises, bruise easily?			
Gastrointestinal			
Any ulcers, hiatal hernia, acid reflux disease?			
Gallbladder conditions, GI / Rectal bleeding			
Psychiatric			
Any depression, anxiety, panic disorder, claustrophobia?			
Developmental delays?			
Neurological			
Any seizures, paralysis, dementia, Parkinsons, **stroke or TIA?**			**Date: ____/____/____**
Musculoskeletal			
Any neck, back, or jaw problems, joint replacement?			
Is neck movement restricted? Can you lay flat?			
Multiple sclerosis, muscular dystrophy, arthritis?			
Hematological and Blood Disorders			
Recent blood transfusion, blood clots, anemia, sickle cell disease?			**Date: ____/____/____**
Are you taking any blood thinners, aspirin, ibuprofen, vitamin E?			
History of hemophilia?			
Liver			
Jaundice, cirrhosis, hepatitis ❒ A ❒ B ❒ C,			
Thyroid			
Hypothyroidism? Hyperthyroidism?			
Kidney			
Burning, bleeding when urinating? Infection?			Frequency:
Pain			
Do you have chronic pain? Location:			Pain scale: (0-10) How long? _____
Other			
Alcohol use, recreational drugs, substance abuse, HIV?			Amount: _____
Do you have or have you ever had cancer? Type: _____			
Have you been hospitalized in the last six months?			Reason/Date:
Women			
Pregnant or trying to get pregnant? Last menstrual cycle			Date: ____/____/____
Doctors			
Please list physicians who care for you on a regular basis and/or during the past year.			
Physician: Specialty:			Phone number:
Physician: Specialty:			Phone number:

Patient Signature: _____ Date: _____/_____/_____

RN / LPN Reviewer Signature: _____ Date: _____/_____/_____

MD Reviewer Signature: _____ Date: _____/_____/_____