NASHUA Eye ASSOCIATES

NOVAMED SURGERY CENTER OF NASHUA

Anesthesia Pre-Operative Evaluation

To be filled out by patient

Patient Name:_____ Date:_____

Surgeon:_____ Surgery Date:_____

Height: ____ft. ____in. Weight: _____lbs.

Previous Surgeries	Year	Type of Anesthesia	Complications

Have you ever had a heart attack? When? _____	Yes	No
Do you have a heart murmur/ abnormal heart rhythm? Symptomatic?	Yes	No
Do you have a pacemaker/defibrillator?	Yes	No
Do you have angina? How often? _____	Yes	No
Episodes of pain or heaviness in your chest?	Yes	No
Do you have a clotting or bleeding disorder?	Yes	No
If yes, explain: _____		
Do you get shortness of breath?	Yes	No
Shortness of breath climbing stairs?	Yes	No
Shortness of breath climbing two flights of stairs?	Yes	No
Do you have sleep apnea, asthma, or lung disease?	Yes	No
CPAP or oxygen use at night?	Yes	No
Do you have a history of stroke, seizures, or convulsions?	Yes	No
Have you experienced fainting or lightheadedness in the past?	Yes	No
Do you have chronic or migraine headaches?	Yes	No
Have you had trouble with numbness, tingling or loss of strength in your arms or legs?	Yes	No
Do you have a history of motion sickness or claustrophobia?	Yes	No
Have you ever had MRSA?	Yes	No

Do you have any other medical problems or major illnesses? Yes No

If yes, explain: _____

Do you have kidney disease? Yes No

If yes, do you have dialysis? Yes No

Do you have liver disease? Yes No

Do you smoke or have you ever smoked? Yes No

If yes, how much? _____ How long?_____When did you stop? _____

Do you drink alcoholic beverages? Yes No

If yes, how much? _____ How long?_____When did you stop? _____

Have you or a close relative ever had a problem with anesthesia? Yes No

If yes, explain: _____

Have you had a cold, sore throat, or hoarseness in the past two weeks? Yes No

Have you experienced recent nausea, vomiting or diarrhea? Yes No

Do you have dental plates, bridges, caps, or loose teeth? (circle which one) Yes No

Do you currently or have you ever taken any of the following medications? Yes No

Please circle: Flomax (Tamsulosin) Cadura (Doxazosin) Uroxatral (Alfuzosin)

Hytrin (Terazosin) Prazosin (Minipress)

Do you have an activated Durable Power of Attorney for healthcare (DPOAH)? Yes No

If activated, please provide a copy of the activated DPOAH document, and fill in the below information.

DPOAH Name:_____ Phone Number:_____

Please initial the following:

_____ I have received, understand, and agree to comply with the patient responsibilities and protocol of conduct of the Nashua Eye Surgery Center.

_____ I understand that I am responsible for:

- Obtaining a pre-operative evaluation and any other required testing with a report sent to my surgeon's office at least 1 week prior to my scheduled surgery date. Otherwise, the surgery date will be postponed until all necessary items are on file with the surgeon.
- Arranging for a reliable adult to be available by telephone before, during, and after my surgery. I realize that my reasonable adult must accompany me into the center upon my arrival and escort me directly to my home when contacted by the staff at the center. I realize that I will not be admitted to the center and the surgery will be rescheduled if my responsible adult is not available or reachable by phone during my time at the surgery center.

_____ _____

Authorized Signature Date

_____

Name/Relation of Authorized Signer (if not patient)

Allergy/Medication Sheet

To be filled out by patient

Patient Name:_____ DOB:_____

Check if no know allergies or sensitivities.

List all allergies or sensitivities here:

	Allergy	Reaction		Allergy	Reaction
1			6		
2			7		
3			8		
4			9		
5			10		

**If you have an allergy to tropical fruits or Latex, please explain: _____

List all medications, supplements, and herbals here: *Staff Use Only*

	Medication	Dose	Frequency	*Last Taken*	*Last Taken*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Place Patient Label Here	Place Patient Label Here

Reviewer:_____ Reviewer:_____

CRNA:_____ CRNA:_____