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

**PRE-ANESTHESIA ASSESSMENT**

**The information you provide on this form is used in the development of your anesthesia care plan. Please complete all fields completely and accurately. Failure to do so may result in delay of your surgery. If additional information is needed, a nurse from EAESC will contact you at the number(s) provided below. Please save our number (470-410-8120) in your phone to ensure our calls are not blocked as spam. Thank you for allowing us to care for you!**

| **Patient Demographics** | |
|---|---|
| Name: | Preferred Name: |
| Date of Birth: | Sex: ☐ Male ☐ Female |
| Cell Phone: | Home Phone: |
| Emergency Contact: | Contact's Phone: |
| Name of responsible adult driving patient home from surgery: | |
| **Height/Weight** | |
| HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs | (weight approximation within 10 lbs is acceptable, but answer is required!) |
| **Special Questions** | |
| ☐ Yes ☐ No Have you had a heart attack, stroke, or mini stroke (TIA) within the last 6 months? | |
| ☐ Yes ☐ No Do you have a pacemaker or implanted defibrillator? | |
| ☐ Yes ☐ No Do you use home oxygen? If yes, please select: ☐ as needed ☐ at night only ☐ all the time | |
| ☐ Yes ☐ No Are you on dialysis? If yes, please select: ☐ Hemodialysis ☐ Peritoneal dialysis | |
| Dialysis schedule: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday | |
| Dialysis clinic and location: | |
| **Hospitalizations** | |
| Have you been hospitalized for any reason in the last six months? ☐ Yes ☐ No | |
| If yes, list date(s) and reason(s): | |
| **Implants** | |
| Do you have any implants or prostheses? ☐ Yes ☐ No Type: | |
| **Women/Pregnancy** | |
| Please check if one of the following applies to you: ☐ Hysterectomy ☐ Menopause | |
| If not, are you currently or possibly pregnant? ☐ Yes ☐ No | |
| Date of late menstrual period: _____ | |
| **Cancer** | |
| Do you currently or have you ever had cancer? ☐ Yes ☐ No Type: _____ Date: _____ | |
| Indicate any treatment you are **currently undergoing**: ☐ oral chemo ☐ chemo infusion ☐ radiation | |

| **Do you currently or have you ever had: (circle)** | **Yes** | **No** | **Comments/Explanation** |
|---|---|---|---|
| **Cardiovascular** | | | |
| Angina, chest pain, or heart attack | | | Date: |
| Heart surgery, stent, or ablation | | | Date: |
| High or low blood pressure | | | |
| Congestive heart failure | | | |
| Heart valve disorder or murmur | | | |
| Irregular heart beat or arrhythmia | | | |
| Other: _____ | | | |

| Do you currently or have you ever had: (circle) | Yes | No | Comments/Explanation |
|---|---|---|---|
| **Diabetes** | | | |
| Controlled by: ☐ Diet ☐ Oral meds ☐ Insulin ☐ Pump | | | |
| **Pulmonary** | | | |
| Asthma, restrictive airway, COPD, or other lung disease | | | |
| Tobacco use | | | _____ packs per day (if applicable) |
| Sleep apnea | | | If yes, do you use a CPAP or BiPAP machine? ☐ Yes ☐ No |
| History of or recent exposure to tuberculosis | | | |
| **Impairments/Disabilities** | | | |
| Hearing or vision impairment | | | |
| Mobility restriction: ☐ Cane ☐ Walker ☐ Wheelchair | | | Able to stand/pivot? ☐ Yes ☐ No |
| **Dental** | | | |
| Dentures, bridges, caps, crowns, chipped or loose teeth | | | |
| **Skin** | | | |
| Current burns, rashes, bruises, or easy bruising | | | |
| **Gastrointestinal** | | | |
| Ulcers, hiatal hernia, or acid reflux disease | | | |
| Gallbladder condition or GI/rectal bleeding | | | |
| **Psychiatric** | | | |
| Depression, anxiety, panic disorder, or claustrophobia | | | |
| **Neurological** | | | |
| Seizure disorder, paralysis, or Parkinson's | | | |
| Alzheimer's or other dementia | | | |
| Stroke or mini stroke (TIA) | | | Date: |
| **Musculoskeletal** | | | |
| Neck, back, or jaw problems or joint replacement | | | |
| Multiple sclerosis or muscular dystrophy | | | |
| Arthritis | | | |
| Is your neck movement significantly restricted? | | | If yes, explain: |
| Are you able to lie flat? | | | If not, explain: |
| **Thyroid** | | | |
| Hypothyroidism or hyperthyroidism | | | |
| **Hematological and Blood Disorders** | | | |
| Recent blood transfusion or anemia | | | |
| Bleeding or clotting disorder or history of blood clots | | | If yes, explain: |
| Current use of blood thinners or Aspirin | | | |
| HIV or other blood transmissible infection | | | |
| **Liver** | | | |
| Jaundice, cirrhosis, or hepatitis ☐ A ☐ B ☐ C | | | |
| **Kidneys** | | | |
| Chronic kidney disease | | | If yes, what stage? |
| Kidney transplant or nephrectomy (removal of kidney) | | | Date: |
| **Alcohol/Recreational Drug Use** | | | |
| Alcohol use | | | _____ drinks per day (if applicable) |
| Recreational drug use | | | If yes, what: |

| **Current Medications (please complete all fields)** | | |
|---|---|---|
| Name | Dose | How Often |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ No current medications

| **Allergies/Intolerances (please include details of reaction)** | |
|---|---|
| Medication | Reaction |
| | |
| | |
| | |
| | |
| | |

☐ No medication allergies or reactions

| **Surgical History** | |
|---|---|
| ☐ No prior surgical history | |
| Procedure: | Date: |
| Procedure: | Date: |
| Procedure: | Date: |
| Procedure: | Date: |

| **Anesthesia History** |
|---|
| Have you or anyone in your family had an unusual reaction to anesthesia, such as:<br>☐ N/A ☐ high temperature (malignant hyperthermia) ☐ difficulty waking up ☐ nausea/vomiting |
| If yes, please explain: |

| **Providers/Specialists** | | |
|---|---|---|
| IMPORTANT: Include full names of your primary care provider as well as any specialists (cardiologist, pulmonologist, neurologist, endocrinologist); **failure to do so may result in delay of your surgery.** | | |
| Provider: | Specialty: | Phone: |
| Provider: | Specialty: | Phone: |
| Provider: | Specialty: | Phone: |

Patient Signature: _____ Date: ____/____/____

RN Reviewer Signature: _____ Date: ____/____/____

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