



Pre-Anesthetic Questionnaire

Date of Surgery ___/___/___

Patient Name _____

Surgeon _____

Height _____ Weight _____ (pounds) _____ (kg)

Drug allergies: _____

Latex allergy/sensitivity to tape/band-aids? Circle: Yes No

Prior Surgeries: _____

Procedure _____

Tobacco use? Yes No _____ packs/day x _____ years

Alcohol use? Yes No # drinks per week: _____

Have Pain? Yes No Where: _____ 1-2-3-4-5-6-7-8-9-10

List medications/supplements: _____

**Anesthesia problems for you or any blood relative?: Yes No If yes, explain: _____

Which of the following do you have or have you had in the past?: Circle "YES" or "NO"

Table with columns for medical conditions (Chest Pain, Heart Attack, etc.), Yes/No responses, and DO YOU: sections (Wear contact lenses, etc.).

Comments: Next of kin/Emergency Contact (Name/phone number): _____

Day of Surgery

Who is to receive D/C instructions?: _____ Who is to receive surgery results?: _____

- Procedure Verified, Site Verified Left / Right Pt. Notified of Advance Directive Policy Social Assessment Patient Questionnaire Reviewed Day of Surgery Signature: _____ Date: _____

Anesthesia History Chart Reviewed PAQ Reviewed Patient Interviewed Patient Examined Anesthesia Evaluation: _____ NPO after: _____ Lungs Heart MP Class I II III IV ASA Status: 1 2 3 4 5 E. Anesthetic: General Block Bier MAC Spinal/Epidural

Anesthesiologist Signature _____

Date _____

Consent for Administration of Conscious Sedation

I understand that it will be necessary to be placed under conscious sedation so that my physician can perform the surgery or procedure. I consent to the use of conscious sedation as deemed necessary and appropriate by my physician.

Conscious Sedation Involves Risks In Addition to the Risks of the Surgical Procedure Itself

These risks may include, but are not limited to, adverse drug reactions, brain damage, nerve injury, damage to teeth or dental work, damage to vocal cords, respiratory problems, minor pain and discomfort, damage to arteries or veins, headaches, backaches or worsening of pre-existing disease(s). The purpose, necessity, and risks of conscious sedation have been explained to my satisfaction by _____ M.D. and there has been sufficient opportunity to discuss the proposed treatment and associated risks.

I hereby consent to an alternative type of anesthesia, if necessary, as deemed appropriate by my physician. Alternative types of anesthesia will be provided by Broad Anesthesia Associates, all of whom are credentialed to provide anesthesia services at this health facility. I understand that conscious sedation is planned for my procedure, and that the anesthetic technique to be used is determined by many factors, including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthetic technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used, including general anesthesia. Although rare, unexpected severe complications with anesthesia can occur, and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia.

I understand that if I am pregnant or there is any possibility that I may be pregnant, I must inform the Surgery Center immediately since this could cause harm to my child or myself.

I DECLARE AND REPRESENT THAT I HAVE READ THE ABOVE AND UNDERSTAND IT IS TRUE.
No guaranty or warranty had been made as to the result of the procedure and/or conscious sedation.

Patient's Signature (or person authorized to consent)

Relationship to Patient

Witness

Date/Time

<u>To be Completed by Physician</u>		
Physical Exam	Physician	<u>Straight Local</u>
NPO after Midnight Yes / No	Cleared for Surgery Yes / No	PAQ History Reviewed
Lungs <input type="checkbox"/> Un remarkable _____	Risks/Benefits Discussed Yes / No	Mental Status Assessed <input type="checkbox"/>
Heart <input type="checkbox"/> Unremarkable _____	Type of Anesthesia	Comments : _____
Labs WNL Yes / No	Conscious Sedation / Local	_____
ASA Status I II III IV		_____
Comments: _____		_____
_____		_____
Physician Signature (Conscious Sedation Only)		Physician Signature