ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων

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Pre-Anesthetic Evaluation Form

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Patient Name:

DOB:

Surgery Date:

Current Date:

Occupation: Current Address:

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Family Doctor: _____ Family Doctor's Phone:

_____

Age: Height: Weight: _____ Surgeon:

_____

Emergency Contact: _____ Relationship: Their Number:

Will someone be with you the first 24 hours after surgery? □ YES □ NO Their Name:

_____

Are you allergic to anything (Medications, Latex, Betadine, Alcohol, Foods, Tape, etc)?

_____

- What medications do you take regularly? _____
- What medications do you take occasionally? _____
- List any previous surgeries you have had: _____
- What is your primary foot problem? _____
- Do you have a history of cancer? □YES □ NO Does your family? □YES □ NO
- Do you have a history of heart problems? □YES □ NO Does your family? □YES □ NO
- Do you have a history of circulation problems? □YES □ NO Does your family? □YES □ NO
- Do you have a history of skin problems? □YES □ NO Does your family? □YES □ NO
- Do you have a history of severe injuries? □YES □ NO
- Do you have a history of any other illnesses? □YES □ NO Does your family? □YES □ NO
- Do you smoke? □YES □ NO If yes, how many packs/day?____For how many years?_____
- Do you drink? □YES □ NO If yes, how many times/week?_____ How much?_____
- Do you take cortisone or steroids? □ YES □ NO Is there any chance you may be pregnant? □ YES □ NO

Do you have any of the following?

- Acid Reflux? □ YES □ NO
- Herpes? □YES □ NO
- AIDS/HIV? □YES □ NO
- High Blood Pressure? □ YES □ NO
- Hepatitis? □YES □ NO
- Tuberculosis? □YES □ NO

- Sleep Apnea? □ YES □ NO
- Hiatal Hernia? □YES □ NO
- Thyroid/Goiter? □YES □ NO
- Epilepsy? □ YES □ NO
- Stroke? □ YES □ NO
- Unconsciousness? □ YES □ NO
- Bronchitis/Asthma? □ YES □ NO
- Emphysema? □ YES □ NO
- Shortness of Breath? □ YES □ NO
- Kidney Disease? □ YES □ NO
- Neck Trouble? □ YES □ NO
- False/Capped Teeth? □ YES □ NO
- Bleeding Problems? □ YES □ NO
- Clotting Problems? □ YES □ NO
- Sickle Cell Disease? □ YES □ NO
- Diabetes? □ YES □ NO
- Sickle Cell Trait YES NO
- Do you treat your diabetes with □ Medicine? □ Diet? □ Insulin?
- If you answered yes to any of the above, please explain:

  _____

_____

Do you have any problems with:

- walking? □ YES □ NO
- hearing? □ YES □ NO
- seeing? □ YES □ NO
- communicating? □ YES □ NO

Do you have any disease or symptom that can be transmitted? □ YES □ NO

Is this your first anesthetic? □ YES □ NO Date of last anesthetic?_____

Have you ever had any problems with any type of anesthesia? □ YES □ NO, If yes, please explain:

_____

Has any of your family members ever had a problem with any type of anesthesia? □ YES □ NO