

# University Pain Clinic Pre-OP Evaluation Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Procedure: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Male \_\_\_\_\_ Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Allergies (medication, latex, food): \_\_\_\_\_ None Yes-please list all \_\_\_\_\_

**Past Surgical History:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:** include Herbal and over the counter: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History:** Please check either Yes or No. If there is more than one choice, circle the one that pertains. Do you have or have you had in the past:

	Yes	No		Yes	No
Problems with anesthesia: Patient Family _____			Hiatal Hernia/Ulcers/Gastritis/Reflex _____		
Bleeding/Clotting disorder _____			Diabetes _____		
Blood Thinner Usage _____			Seizures/Epilepsy/Blackouts _____		
High Blood Pressure/Stroke _____			Arthritis/Neck Problems _____		
Cardiac (heart) Problems _____			Kidney/Liver Disease _____		
Chest Pain/Angina/Pacemaker _____			Bladder/Prostate Problems _____		
Shortness of Breath/Cough/Pneumonia _____			Anemia/Sickle Cell Disease _____		
Bronchitis/Emphysema/Asthma _____			Thyroid Disease/Goiter _____		
Recent Cold/Sore Throat _____			History of street or social drug use _____		
Do you currently smoke: ___ ppd for ___ yrs _____			Drink alcohol - How much _____		
Special weight loss diet/meds _____			Cancer _____		
Glaucoma/Other visual problems _____			Could you be pregnant _____		
Recent exposure to a communicable disease _____			Last menstrual period _____		
TB HIV Hepatitis Other _____			Get car, air, sea or motion sickness _____		
Aspirin/Anti-inflammatory use _____			Other: _____		

**Patient – STOP – do not fill out below.**

**Anesthesia**

Review/Comment: \_\_\_\_\_

Anesthesia Plan/risks discussed with patient/guardian; patient understands/accepts: \_\_\_\_\_ Yes

Signature: \_\_\_\_\_ Date: \_\_\_\_\_