CentraState Medical Center

901 West Main Street Freehold New Jersey 07728

Anesthesia and Surgical Pre-Admission Assessment

Patient Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Primary Physician Name: _____

What type of surgical procedure (operation) are you having?

_____

_____

Do you have medication allergies and or reactions ? YES ☐ NO ☐ List below.

_____

_____

Have you had any of the following symptoms or illnesses? (YES or NO)

High blood pressure ? _____ ☐YES ☐NO
Heaviness, lightness or pain in your chest during or after physical activity ? _____ ☐YES ☐NO
Heart attack ? _____ ☐YES ☐NO
Heart murmur ? _____ ☐YES ☐NO
Heart beating rapidly or irregular ? _____ ☐YES ☐NO
Swelling in the ankles or fluid in the lungs ? _____ ☐YES ☐NO
Pacemaker/ AICD ? _____ ☐YES ☐NO
Do you have heart failure ? _____ ☐YES ☐NO
Have you had a cardiac catheterization, angioplasty or open heart surgery ? _____ ☐YES ☐NO
Asthma ? _____ ☐YES ☐NO
Bronchitis ? _____ ☐YES ☐NO
Smoking related lung disease (Emphysema/COPD) ? _____ ☐YES ☐NO
Do you use oxygen at home ? _____ ☐YES ☐NO
Do you have trouble breathing or are short of breath ? _____ ☐YES ☐NO
Do you have sleep apena ? _____ ☐YES ☐NO
Bleeding tendency or easy brusing ? _____ ☐YES ☐NO
Blood clot in your legs or lungs ? _____ ☐YES ☐NO
Have you had a transfusion of blood ? _____ ☐YES ☐NO
Is there a family history of DVT or pulmonary embolism ? _____ ☐YES ☐NO
Have you been told you have a coagulation disorder ? _____ ☐YES ☐NO
Do you have varicose veins ? _____ ☐YES ☐NO
Do you have a PICC line, Permcath or Mediport ? _____ ☐YES ☐NO
Diabetes (sugar in urine) ? _____ ☐YES ☐NO
Problems with your thyroid gland ? _____ ☐YES ☐NO
Do you have kidney problems ? _____ ☐YES ☐NO
Are you on dialysis ? _____ ☐YES ☐NO

Additional questions on the back of this form

Frequent heart burn or ulcer ? ☐YES ☐NO
Do you have liver disease, jaundice, hepatitis or cirrhosis ? ☐YES ☐NO
Seizure ? ☐YES ☐NO
Stroke ? ☐YES ☐NO
Paralysis ? ☐YES ☐NO
Parkinson's Disease ? ☐YES ☐NO
Do you have a disease severely restricting neck movement or mouth opening ? ☐YES ☐NO
Do you have a nurse aide or nursing care ? ☐YES ☐NO
When was your last menstrual period ?
Are you pregnant now ? ☐YES ☐NO
Have you ever smoked ? ☐YES ☐NO
Do you drink alcohol ? ☐YES ☐NO
Did you or a family member ever experience a problem with anesthesia ? ☐YES ☐NO
Do you have concerns about your anesthesia ? ☐YES ☐NO
Have you ever had past surgeries ? ☐YES ☐NO
List surgeries and dates: