NEW AGE | Medical Aesthetics & Plastic Surgery

**Patient Name:**_____

**DOB:**_____

## Pre-Anesthesia Assessment

### ANTHROPOMETRY

What is your age: _____ BMI:_____

What is your height in cm: _____

What is your weight in kg: _____

Please list all medications and supplements taken regularly:

| DRUG NAME | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |

Do you have any allergies? CIRCLE: Yes / No

Name and reaction_____

_____

| **HEART** *Have you had any of the following heart problems?* | **YES** | **NO** | **Explain** |
|---|---|---|---|
| 1. Do you have occasional chest pain/angina | | | |
| 2. Do you have a heart murmur *(other than a heart murmur as a child that disappeared)?* | | | |
| 3. Do you have a heart valve problem? | | | |
| 4. Do you have irregular heartbeat/arrhythmia or palpitation? | | | |

5. Have you had heart surgery and/or do you have heart stents?

6. Do you have a pacemaker or internal defibrillator?

7. Do you have any other heart disease or details about the answers above?

**Lung & Breathing*:*** *Do you have any of the following lung or breathing problems?*

1. Do you have asthma and use “rescue” puffers more than twice per week because of symptoms?

2. Have you recently had pneumonia?

3. Do you need home oxygen?

4. Do you have Sleep Apnea?

5. Do you use CPAP or BiPAP? (*a machine to help you breathe while you sleep)*

6. Do you have difficulty lying flat due to breathing problems (not due to back pain)?
Any issues opening your mouth?

7. Do you have any other lung disease or breathing issues or more details about the answers above?

8. Do you smoke cigarettes, or have you ever smoked cigarettes?

a. How many years have you smoked?

b. If you used to smoke, when did you quit?

**Blood and Coagulation**

1. Do you have Anemia (low blood count)?

2. Is there anyone in your family with a Coagulation Disorder *(e.g. Hemophilia, Von Willebrand Disease)*

3. Are you currently taking a blood thinner other than aspirin?

4. Do you have excessive bleeding with surgery or periods?

6. If required in a rare emergency, would you accept a blood transfusion?

7. Do you have Sickle Cell Anemia (not sickle cell trait)

8. Do you have a history of Deep Vein Thrombosis or Pulmonary embolism?

9. Has anyone in your family been diagnosed with a thromboembolic disorder?

10. Do you have any other blood related problem or more details about the answers above?

**Neurological & Muscular**

1. Are you experiencing any significant memory problems or dementia?

2. Do you experience extreme confusion after an operation?

3. Have you ever had a Mini Stroke (TIA) or Stroke (CVA)?

4. Have you ever had, or do you have a brain aneurysm?

5. Have you ever had, or do you have epilepsy or convulsions?

6. Have you had a seizure in the last two (2) months?

7. Have you had any fainting spells in the past 6 months?

8. Do you have chronic pain requiring regular use of opioids/narcotics? IF SO:
*What was your **best** pain score 0-10 in the last week?*
*What was your **average** pain score 0-10 in the last week?*
*What was your **worst** pain score 0-10 in the last week?*

9. Do you take opioid/narcotic medications more than twice daily for pain?

**Other**

1. Have you or your family (blood relatives) had a serious reaction to anesthesia (other than nausea or vomiting)?

2. Do you have Diabetes that requires insulin?

3. Do you have any kidney problems *(other than kidney stones)?*

4. Do you have a uncontrolled over or under active thyroid?

5. Do you have liver disease other than fatty liver?

6. Have you had an organ transplant other than cornea?

7. Do you have Rheumatoid Arthritis (not osteoarthritis)?

8. Do you have an Autoimmune disease?

9. Do you have inflammatory bowel disease?

10. Have you ever had Cancer?

11. Have you had radiation to your head and/or neck?

12. Do you drink more than 7 alcoholic beverages per week? If so, how much?

13. Do you take any street drugs (other than cannabis)? _____

14. Are you currently pregnant? _____

15. Is there a possibility that you are currently pregnant? _____

16. Are you on Oral Contraception or Hormone Replacement Therapy? _____

Please list any other medical problems not listed above: _____

_____

_____

_____

_____

Please list all surgeries requiring anesthesia & any hospital admissions:

| Year | Surgery or Hospital Admission | Year | Surgery or Hospital Admission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Day Of Surgery Details:**

**Emergency Contact Name:** _____

**Relationship:** _____

**Phone Number:** _____

**Name & phone number of driver picking you up after surgery:** _____

_____

**Signature of Patient:** _____ **Date:**_____