HISTORY AND PHYSICAL/ANESTHESIA RISK AND EVALUATION

Eagle Eye Surgery and Laser Center			Patient Name:	
Surgery Date:			Date of Birth:	
Primary Care Physician:			PCP Phone Number:	
Past Medical History **Check appropriate Yes/No responses and circle all types that apply.**				**Explain with dates if known**
Yes	No	Heart problems?	Types: Heart attack, heart failure, chest pains, pacemaker, pacemaker with defibrillator *(if defibrillator, card should be sent to ASC prior to surgery, for instructions for surgery)* heart valve problems, other?	
Yes	No	Blood pressure problems?	On treatment plan, advised to be on treatment but not currently on plan, never been told B/P was an issue	
Yes	No	Respiratory Problems	Types: Asthma, emphysema, sleep apnea, CPAP, severe snoring, home oxygen _____liters, recent cold or cough, shortness of breath with exercise or lying flat.	
Yes	No	Tobacco Use	Have you ever or do you currently use tobacco? Cigarette, cigar, chewing tobacco If you quit, when _____	Amount per day _____ # years used _____
Yes	No	Thyroid/Gland problems?	Type?	
Yes	No	Diabetes or blood sugar problems	How is it controlled? Diet/exercise, oral pills, insulin	Fasting glucose must be below 300 prior to elective surgery
Yes	No	Kidney problems? **males any**-prostate problems?	Ever used a medication called Flomax?	
Yes	No	Frequent heartburn, ulcers or other stomach or esophagus problems?	Reflux?	
Yes	No	Liver problems?	Types: hepatitis ___, cirrhosis, other?	
Yes	No	Muscle or bone problems?	Type: neck problems, back problems, arthritis, osteoporosis, polio, fibromyalgia	
Yes	No	Neurological problems?	Types: stroke, seizures, Parkinson's disease, headaches, nerve damage, MS	
Yes	No	Clotting Problems?	Types: blood clots in legs or lungs Use of blood thinners	
Yes	No	**(Females only)** Is there a chance you could be pregnant?	Last menstrual period _____ Hysterectomy?	A pregnancy test may be required depending on the type of anesthesia.
Yes	No	Infectious Diseases	History of MRSA? Other?	
Information provided by:_____ Information transcribed by:				Date:_____ (within 30 days of surgery) Time: _____

Please time, date and sign for any additional information added to this form after completion

Name		DOB		
Yes	No	Are there any other medical conditions you haven't listed?		
Yes	No	Do you have any loose teeth, bridgework, caps, or dentures?		
Yes	No	Have you or a family member had problems with anesthesia or Malignant Hyperthermia?		
List meds & dose. Include over the counter meds and herbal supplements		Medication _____ Dose _____ _____ _____ _____ _____ _____ _____ _____ _____ **If you use a second sheet to put meds on, it must have name, date of birth, medication and dose.**		Medication _____ Dose _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
List any allergies & reactions		Medication Allergy _____ **Reaction** _____ _____ _____ _____ _____		Food /Other Allergy _____ **Reaction** _____ _____ _____ _____ _____
Previous surgeries/dates				

Information provided by: _____Date _____ Time _____
Information transcribed by: (to be completed within 30 days of surgery)

Following sections for ophthalmologist History & Physical				Following section for Anesthesia Use
Height Actual/Stated		Weight		
B/P _____/____ **if over** 150/90 repeat _____/_____ **If over 150/90 on repeat, follow up with Primary Care MD prior to surgery.+**				NPO since:
Pulse				Airway exam:
Heart	Regular Rhythm	Yes	No	ASA Class I II III IV
	Murmor/rubs	Yes	No	Lab results if clinically applicable
Lungs	Lungs Clear	Yes	No	
Neuro	Alert & Oriented x 3	Yes	No	
Patient's history reviewed. Comments:				Additional Comments:
Surgeon Signature Date Time				
Anesthesia Risk and Evaluation. I have evaluated the patient for risks associated with planned anesthesia and the procedure to be performed. I found the patient an acceptable candidate.				
History & Physical: I have examined the patient and reviewed the H & P. No change ☐ or list any changes (list below)				H & P reviewed. Risks, benefits and options for anesthesia have been reviewed. (See detailed anesthesia consent). Questions were answered. Patient wishes to proceed. Anesthesia plan collaborated with MD.
Allergies: No change ☐ Note changes here _____ The patient meets ASC admission criteria and the plan is to proceed with surgery.				Anesthesia Signature
Signature Date Time				Date Time