GEORGIA ENDOSCOPY CENTER, LLC
AND
ENDOSCOPY CONSULTANTS, LLC

PRE-PROCEDURE ANESTHESIA EVALUATION

DO YOU HAVE OR HAVE YOU HAD:

☐ Yes ☐ No **Any ALLERGIES** to food, chemicals, **medications**, shellfish, **latex**? If yes, specify:
_____

☐ Yes ☐ No Have you had anything to eat or drink since **midnight**? If yes, what?_____
☐ Yes ☐ No Are you or could you be **pregnant**?
☐ Yes ☐ No Personal or family history of problems with anesthesia? (Including high fever)
☐ Yes ☐ No Difficult intubation?
☐ Yes ☐ No Have you ever experienced excessive drowsiness, respiratory or cardiac problems following sedation?
If yes, specify:_____
☐ Yes ☐ No Breathing difficulty or sleep apnea?
☐ Yes ☐ No Heart disease (including: heart attack, murmur, pacemaker, bypass surgery, mitral valve prolapse, etc.)?
☐ Yes ☐ No Chest pain?
☐ Yes ☐ No An *abnormal EKG (irregular heartbeat, **MI**)?*
☐ Yes ☐ No Hypertension (high blood pressure)?
☐ Yes ☐ No Elevated cholesterol or lipids?
☐ Yes ☐ No Lung disease (shortness of breath, chronic cough, asthma)?
☐ Yes ☐ No An *abnormal* chest x-ray?
☐ Yes ☐ No Kidney disease? Specify:_____
☐ Yes ☐ No Liver disease/hepatitis/jaundice? Reflux? Specify:_____
☐ Yes ☐ No Bleeding or clotting abnormalities? Specify:_____
☐ Yes ☐ No Diabetes?
☐ Yes ☐ No Thyroid or goiter problems?
☐ Yes ☐ No Epilepsy/seizures? Neurological problems?
☐ Yes ☐ No Back trouble or neck problems? Specify:_____
☐ Yes ☐ No Advanced rheumatoid arthritis?
☐ Yes ☐ No TMJ syndrome or history of facial fracture?
☐ Yes ☐ No Past/present possible carrier of contagious disease? Specify:_____
☐ Yes ☐ No Any alcohol use?_____ How much?_____
☐ Yes ☐ No Do you currently smoke or have you ever smoked? Amount per day:_____How long?_____
☐ Yes ☐ No Have you taken medicine or products containing **aspirin or blood thinners** the past 5 days?
List:_____Last taken on _____
☐ Yes ☐ No Are you currently taking any herbal supplements/medication? List:_____

Please list all medications that you are **currently** taking. (Attach list if necessary)

Medication	Dosage	Frequency

DO YOU HAVE ANY OF THE FOLLOWING?
☐ Yes ☐ No A. Dentures _____ B. Partial Plate_____ C. Bridgework-Permanent_____ D. Caps_____

ARE YOU WEARING ANY OF THE FOLLOWING?
☐ Yes ☐ No A. Contacts_____ B. False Eyelashes_____ C. Wig/Hairpiece_____ Hearing Aid _____

List any other current medical problems:_____

List past surgical history:_____

Pertinent Family History: _____

PATIENT SIGNATURE:_____ DATE _____

ANESTHESIOLOGIST SIGNATURE:_____ DATE _____ TIME _____

Updated 10-1-12