East Atlanta Eye Surgery Center
550 Professional Drive
Lawrenceville, GA 30046

PRE-ANESTHESIA ASSESSMENT

The information you provide on this form is used in the development of your anesthesia care plan. Please complete all fields completely and accurately. Failure to do so may result in delay of your surgery. If additional information is needed, a nurse from EAESC will contact you at the number(s) provided below. Please save our number (470-410-8120) in your phone to ensure our calls are not blocked as spam. Thank you for allowing us to care for you!

Patient Demographics	
Name:	Preferred Name:
Date of Birth:	Sex: ☐Male ☐Female
Cell Phone:	Home Phone:
Emergency Contact:	Contact's Phone:
Name of responsible adult driving patient home from surgery:	
Height/Weight	
HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs	(weight approximation within 10 lbs is acceptable, but answer is required!)
Special Questions	
◯Yes ◉No Have you had a heart attack, stroke, or mini stroke (TIA) within the last 6 months?	
◯Yes ◉No Do you have a pacemaker or implanted defibrillator?	
◯Yes ◉No Do you use home oxygen? If yes, please select: ☐as needed ☐at night only ☐all the time	
◯Yes ◉No Are you on dialysis? If yes, please select: ☐Hemodialysis ☐Peritoneal dialysis	
Dialysis schedule: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday	
Dialysis clinic and location:	
Hospitalizations	
Have you been hospitalized for any reason in the last six months? ◯Yes ◉No	
If yes, list date(s) and reason(s):	
Implants	
Do you have any implants or prostheses? ◯Yes ◉No Type:	
Women/Pregnancy	
Please check if one of the following applies to you: ☐Hysterectomy ☐Menopause	
If not, are you currently or possibly pregnant? ☐Yes ☐No	
Date of late menstrual period: _____	
Cancer	
Do you currently or have you ever had cancer? ◯Yes ◉No Type: _____ Date: _____	
Indicate any treatment you are **currently undergoing**: ☐oral chemo ☐chemo infusion ☐radiation	

Do you currently or have you ever had: (circle)	**Yes**	**No**	**Comments/Explanation**
Cardiovascular			
Angina, chest pain, or heart attack		✔	Date:
Heart surgery, stent, or ablation		✔	Date:
High or low blood pressure		✔	
Congestive heart failure		✔	
Heart valve disorder or murmur		✔	
Irregular heart beat or arrhythmia		✔	
Other: _____			

Do you currently or have you ever had: (circle)	Yes	No	Comments/Explanation
Diabetes			
Controlled by: ☐Diet ☐Oral meds ☐Insulin ☐Pump		✔	
Pulmonary			
Asthma, restrictive airway, COPD, or other lung disease		✔	
Tobacco use		✔	_____ packs per day (if applicable)
Sleep apnea		✔	If yes, do you use a CPAP or BiPAP machine? ☐Yes ☐No
History of or recent exposure to tuberculosis		✔	
Impairments/Disabilities			
Hearing or vision impairment		✔	
Mobility restriction: ☐Cane ☐Walker ☐Wheelchair		✔	Able to stand/pivot? ☐Yes ☐No
Dental			
Dentures, bridges, caps, crowns, chipped or loose teeth		✔	
Skin			
Current burns, rashes, bruises, or easy bruising		✔	
Gastrointestinal			
Ulcers, hiatal hernia, or acid reflux disease		✔	
Gallbladder condition or GI/rectal bleeding		✔	
Psychiatric			
Depression, anxiety, panic disorder, or claustrophobia		✔	
Neurological			
Seizure disorder, paralysis, or Parkinson's		✔	
Alzheimer's or other dementia		✔	
Stroke or mini stroke (TIA)		✔	Date:
Musculoskeletal			
Neck, back, or jaw problems or joint replacement		✔	
Multiple sclerosis or muscular dystrophy		✔	
Arthritis		✔	
Is your neck movement significantly restricted?		✔	If yes, explain:
Are you able to lie flat?	✔		If not, explain:
Thyroid			
Hypothyroidism or hyperthyroidism		✔	
Hematological and Blood Disorders			
Recent blood transfusion or anemia		✔	
Bleeding or clotting disorder or history of blood clots		✔	If yes, explain:
Current use of blood thinners or Aspirin		✔	
HIV or other blood transmissible infection		✔	
Liver			
Jaundice, cirrhosis, or hepatitis ☐A ☐B ☐C		✔	
Kidneys			
Chronic kidney disease		✔	If yes, what stage?
Kidney transplant or nephrectomy (removal of kidney)		✔	Date:
Alcohol/Recreational Drug Use			
Alcohol use		✔	_____ drinks per day (if applicable)
Recreational drug use		✔	If yes, what:

Current Medications (please complete all fields)		
Name	Dose	How Often
☐No current medications		

Allergies/Intolerances (please include details of reaction)	
Medication	Reaction
☐No medication allergies or reactions	

Surgical History	
☐ No prior surgical history	
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

Anesthesia History
Have you or anyone in your family had an unusual reaction to anesthesia, such as: ☑N/A ☐high temperature (malignant hyperthermia) ☐difficulty waking up ☐nausea/vomiting
If yes, please explain:

Providers/Specialists		
IMPORTANT: Include full names of your primary care provider as well as any specialists (cardiologist, pulmonologist, neurologist, endocrinologist); **failure to do so may result in delay of your surgery.**		
Provider:	Specialty:	Phone:
Provider:	Specialty:	Phone:
Provider:	Specialty:	Phone:

Patient Signature: _____ Date: _____/_____/_____

RN Reviewer Signature: _____ Date: _____/_____/_____

MD Reviewer Signature: _____ Date: _____/_____/_____