## NTSC PREOPERATIVE ASSESSMENT

AGE	<del></del>	<del>.,</del>			WEIGHT: n	EIGHI:	<del></del>	T 50
PLACE "X" IN PROPER COLUMN		YES	NO	DONT	PLACE "X" IN PROPER COLUMN	YES	NO	DON'T
	High/Low Blood Pressure	1.20	110	MINOT	PERCE X INTINOLEN COLONIN	120	110	141011
HAVE YOU EVER HAD ANY HEART PROBLEMS?	Pacemaker/Defibrillator	<del></del>		+	DO YOU HAVE ANY INFECTIOUS DISEASES?		ļ	
	Rheumatic Fever				J			
	Heart Attack	-			HEPATITIS HIV TB MRSA		<u> </u>	<u> </u>
	Heart Murmur Chest Pains/Angina		<del>.  </del>	-	PLEASE LIST ANY ALLERGIES YOU HAVE INCLUDING LATEX.			
	Irregular Heart Beat	- <del> </del>	<del> </del>	<del> </del>	-		i	
	CHF		+		-		1	ļ
	Cardiac Cath or Stent	<del> </del>	1	<u> </u>	<del>-</del>	İ	ĺ	ĺ
	Asthma/Wheezing						ļ	
HAVE YOU EVER HAD ANY LUNG PROBLEMS?	Bronchitis/Pneumonia		ļ			<b></b>		ļ
LUNG PROBLEMS?	Shortness of Breath CPAP/O2	ļ	<del> </del>	<del> </del>	PEDIATRIC EVALUATION:			
	Sleep Apnea		<del>                                     </del>	<del></del>	FULL TERM AT BIRTH Y / N PRE TERM < 37 WEEKS Y / N IF YES EXPLAIN i.e oxygen, breathing			
LAST ATTACK	Other	<del>                                     </del>	<del> </del>	+	tube, NICU stay, Bleeding in brain.			
		ļ	<u> </u>					ļ
HAVE YOU EVER HAD ANY URINARY PROBLEMS?	Urinary Infections	ļ		ļ.,.	DEVELOPMENTAL DELAY Y/N EMOTIONAL/BEHAVIORAL/LEARNING DISABILITY Y/N			ĺ
	Kidney Stones Other	ļ	<del> </del>					
	Outer							
HAVE YOU EVER HAD ANY DIGESTIVE TRACT PROBLEMS?	Ulcers/ Hiatal Hernia		1		HAVE YOU EVER HAD ANY SURGERY? PLEASE LIST?			
	Gastritis/ Colitis							
	Nausea/ Vomiting		1	1				
	Motion Sickness Chronic Diarrhea	ļ			4			
	Jaundice	<del> </del>	-		<b>-</b>	1		
	Pancreatitis				1			•
	G-Tube feeding				<b>1</b>			
	Acid Reflux				MEDICATIONS; SEE ATTACHED LIST			
HAVE YOU EVER HAD ANY MUSCLE OR JOINT PROBLEMS?	Arthritis/ Limited Joint				HAVE YOU EVER HAD A PROBLEM WITH AN ANESTHETIC?			
	Motion Broken Bones				MAN IONANT LIVEEDTI EEDINAS			
	Physically Handicapped			ļ	MALIGNANT HYPERTHERMIA?  HAS ANY BLOOD RELATIVE EVER HAD A PROBLEM WITH AN	<del> </del>		
	Muscle Weakness			ļ	ANESTHETIC?			
	Muscle Cramps				ARE YOU PREGNANT?			
	Limited mobility in the Neck				HYSTERECTOMY OR TUBAL LIGATION?	—		
	or Jaw	[			LMP: N/A			
HAVE YOU EVER HAD ANY NEUROLOGY PROBLEMS? LAST EPISODE	Convulsions/Epilepsy				DO YOU SMOKE? PPD YRS QUIT			
	Head Injury/ Fainting Hyperactive, requiring					<del></del>		
	medication?				DO YOU DRINK ALCOHOLIC BEVERAGES?	<del> </del>		······································
	Headaches				DO YOU USE RECREATIONAL DRUGS?	ĺĺ	1	
	MS/ Cerebral Palsy				ANY PROSTHETIC DEVICES i.e glasses, hearing aids, dentures			
	Numbness/Tingling in Extremities				DO YOU HAVE TO TAKE ANTIBIOTICS TO PROTECT YOUR	i 1	- 1	
	Stroke/TIA				HEART BEFORE SURGERY? HAVE YOU EVER HAD A BLOOD TRANSFUSION?			
	Psych History				Notes:			
	Diabetes			· · · · · ·	11000			
METABOLIC PROBLEMS?	Thyroid							
	Other		-				f	
HAVE YOU EVER HAD ANY BLEEDING PROBLEMS?	Anemia Sickle Cell Disease/Trait					1 1	İ	
	Bruise Easily				Completed by :	ı İ		
	Other							
PHYSICAL EXAMINATION/DOS ASA# 1 2 3 4 5 EENT MOUTH TEETH: LOOSE/ CHIPPED/MISSING/BRACES NECK				Respiratory clear bilaterally unless noted below and Cardiac rhythm regula noted below.	r without signi	ificant mur	mur uniess	
HEART LUNGS								
LABS								
SKIN: BRUISES/LESIONS/ RASH								
SIGNED Patient/Guardian				M.D./CRNA DAT	E			
				MI.D.JORIYA DAI			<del></del>	
HEALTH STATUS UNCHANGED DATE SIGNATURE								
								ļ
					PATIENT LABEL			
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