East Columbus Surgery Center
Medication Record

Name_____

Allergies _____

LIST YOUR PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS
Include: pills, liquids, drops, patches, aspirin, vitamins, herbs

Medication	Dosage	Times per Day	Reason for Use

East Columbus Surgery Center
Pre-Anesthesia Evaluation

Name:_____

Date of Surgery:_____

Ht._____ Wt._____

Have you had or do you still have the following?
(Please check appropriate box after each question.)

1. Shortness of breath with minimal exertion?..... YES ☐ NO ☐
2. Asthma or emphysema? ..... YES ☐ NO ☐
3. Do you smoke?..... YES ☐ NO ☐
4. Do you use oxygen at home? ..... YES ☐ NO ☐
5. Are you more short of breath today than usual? ..... YES ☐ NO ☐
6. Do you have trouble climbing two flights of steps?..... YES ☐ NO ☐
7. High or low blood pressure?. ..... YES ☐ NO ☐
8. Does fluid fill up in your heart or lungs? (congestive heart failure) ..... YES ☐ NO ☐
9. Stroke? If Yes, which side effected: (check) **R** ☐ or **L** ☐ ..... YES ☐ NO ☐
10. Heart attack or chest pain? ..... YES ☐ NO ☐
11. Heart races or skips a beat? ..... YES ☐ NO ☐
12. Hospital admission in the past 6 months?. ..... YES ☐ NO ☐
13. Do you bleed easily (trouble with clotting)?.. ..... YES ☐ NO ☐
14. Do you have any "frozen" joints or back problems?..... YES ☐ NO ☐
15. Diabetes, thyroid or recent steroid use? ..... YES ☐ NO ☐
16. Seizures/ kidney/ liver problems?. ..... YES ☐ NO ☐
17. Have you or a family member had problems with anesthesia?..... YES ☐ NO ☐
18. Mastectomy? If Yes, which side: (check) **R** ☐ or **L** ☐ ..... YES ☐ NO ☐
19. Acid reflux or hiatal hernia?..... YES ☐ NO ☐
20. Do you feel any different today than you usually do?. ..... YES ☐ NO ☐
21. Are you extremely nervous about your surgery? ..... YES ☐ NO ☐
22. Allergy to Latex® products? ..... YES ☐ NO ☐

Medication Allergies?_____

Past Surgeries?

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