



**PRE-ANESTHESIA ASSESSMENT FORM**

Name: _____	Diagnosis: _____
CID/HRN _____ Age/Sex _____	Procedure planned: _____ On Date: _____
Ward _____ Bed no. _____	Department: _____ Body Wt _____ Kgs Height _____ BMI _____

**Summary Of Medical History:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Previous Surgery	Year	Type of Anesthesia	Complications/Problems	Family Hx Anesthesia Complicator <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Describe _____ <input type="checkbox"/> Allergy <input type="checkbox"/> Alcohol <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Regular <input type="checkbox"/> Smoking: _____ Pack/day _____ yrs <input type="checkbox"/> Stopped <input type="checkbox"/> Drug Abuse: _____
_____	_____	_____	_____	_____
Current Meds _____	_____			

**Physical Examination / Systemic reviews**

**Vital signs:** Temp \_\_\_\_\_ °C, RR \_\_\_\_\_ /min. BP \_\_\_\_\_ / \_\_\_\_\_ mmHg, Pulse \_\_\_\_\_ /min. SPO<sub>2</sub> \_\_\_\_\_ % (FIO<sub>2</sub> \_\_\_\_\_ ) Pallor \_\_\_\_\_

**Airway:** Mouth Opening  Nil  Limited.....fingers. Neck movements:  Nil  Limited **OSA**  Nil  Mild  Severe  
 Malampati: 1 2 3 4 Thyromental \_\_\_\_\_ cm Neck mass:  Yes  No. If Yes \_\_\_\_\_

**Potential Dental Damage:**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
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 } × Missing. Patient Informed  Yes  No  
 Dentures  Yes  No } ○ Loose. Expected difficult airway  Yes  No

**Neuro:** Mental status:  Normal  Impaired  Previous CVAs \_\_\_\_\_  Seizures.  Syncope: \_\_\_\_\_  
 Weakness \_\_\_\_\_  Myopathies: \_\_\_\_\_  Chronic pains: \_\_\_\_\_  Others: \_\_\_\_\_

**Cardiovasculars:**  NAD  HTN..  well controlled,  poorly controlled  IHD \_\_\_\_\_  Arrhythmias: \_\_\_\_\_  
 Heart Failure: NYHA Class \_\_\_\_\_  Dyslipidemia:  Palpitation. LVEF \_\_\_\_\_ %  Valvular dis: \_\_\_\_\_  
 Others \_\_\_\_\_

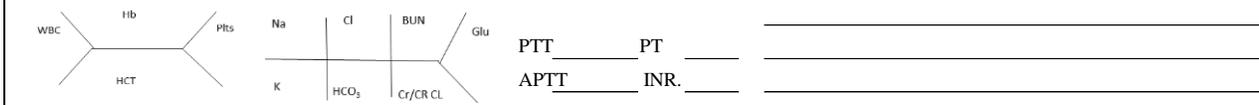
**Respiratory:**  NAD  COPD  Asthma  Recent URI  TB  Cough  Dyspnea  Others \_\_\_\_\_  
 Auscultations: Heart: \_\_\_\_\_ Lungs: \_\_\_\_\_

**Gastrointestinal:**  NAD  GERD  Jaundice  Cirrhosis  Others: \_\_\_\_\_

**Renal:**  CRF: CCr \_\_\_\_\_ ml/min.  ESRD  Dialysis \_\_\_\_\_  Others \_\_\_\_\_

**Endocrine:**  NAD  DM Type 1 / 2 HB 1c \_\_\_\_\_ Thyroid:  Normal  Hyperthyroid  Hypothyroid  Adrenal \_\_\_\_\_  
 LMP \_\_\_\_\_ **Others:** \_\_\_\_\_

**Lab:** CBC Date: / / Boichemistry dat / / / Coagulation date / / / **Other Labs:** \_\_\_\_\_



CXR \_\_\_\_\_ ECG \_\_\_\_\_

Other Investigations: \_\_\_\_\_

Consultation  Yes  No. If Yes Consultation: \_\_\_\_\_  
 Accepted  Not accepted  Reason \_\_\_\_\_

ASA: ( Circle) 1 2 3 4 5 E **Anesthesia Plan:** \_\_\_\_\_

Risk, Benefit, Alternatives discussed with  Patient  Parents, Who agreed plan  Yes.  No. Name and Relationship to Patient \_\_\_\_\_

Consent:  Normal  Moderate Risk  High Risk Risk: \_\_\_\_\_

**Arrange blood component:**  PRC \_\_\_\_\_ Units,  Whole Blood \_\_\_\_\_ Units  FFP \_\_\_\_\_ Units  Platelets \_\_\_\_\_ Units. **Book ICU / HDU**  Yes  No

**Pre-op Advice and Pre-meds:** \_\_\_\_\_

\_\_\_\_\_ PAC done by: \_\_\_\_\_ Sign \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed the above information and reassessed the patient which reveals:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Name \_\_\_\_\_ Sign \_\_\_\_\_ Date \_\_\_\_\_