

Dr. Bill Chow – PreOperative Surgical Information FAX: (403)254-5887
PRE-ANESTHESIA HISTORY AND PHYSICAL EXAMINATION FORM

Surgery Date: _____

Procedure: _____ Surgeon: _____

Patient Name: _____ Birthdate: _____

Family History of anesthesia problems? NO YES _____

Previous Surgery: _____

ALLERGIES: (include tape and Latex and indicate severity of reaction) _____

Medications:

1. Diabetic NO YES Oral Hypoglycemic: _____

Insulin Injection: _____

2. Anticoagulants: NO YES Coumadin: Other: _____

Last INR Result: _____ Date: _____

3. ASA (Aspirin): NO YES Self medicated? OR Under physician instruction?

***If yes, can the patient discontinue ASA 3 days prior to surgery? NO YES**

4. Other Medications: _____

History & Systems Review:

CNS: _____

GI/ABD: _____

ENT: _____

GU: _____

CVS: _____

SKIN: _____

RS: _____ O₂ Rate _____

Mus/Skel: _____

EXAMINATION: P: _____ B/P: _____

HT: _____ WT: _____

CNS: _____

GI/ABD: _____

ENT: _____

GU: _____ Flomax?: NO YES

CVS: _____

SKIN: _____

RS: _____

Mus/Skel: _____

Comments: _____

Laboratory Req: Blood Urine ECG

Is this patient fit to safely undergo local/ regional anesthesia and the proposed surgery? NO YES

Date of Examination: _____

Signature of Physician: _____

Name & Address (Print): _____
