PATIENT NAME:	DATE OF BIRTH:	DATE OF SEDATION:

PARENT NAME: _____

PHONE #: _____

E-MAIL:

Anesthesia Alternatives
on-site anesthesia services

PRE-OPERATIVE ANESTHESIA EVALUATION

Anesthesia Alternatives, PLLC
9002 Six Pines Dr.
Office # 142
The Woodlands, TX 77380
281-703-9686

WEIGHT: _____

HEIGHT: _____

GENDER:
M **O** F **O**

MALLAMPATI: _____

BRODSKY: _____

BMI:

Drug or Food Allergies:	Current Medications:	Procedure:	Estimated Anesthesia Time:	Dentist:

Does the patient have or had any:		**Airway/Anesthesia History:**
1. Prior surgeries or hospitalizations?	Yes **O** No **O**	
2. Problems with previous anesthetics?	Yes **O** No **O**	
3. Family history of anesthesia problems?	Yes **O** No **O**	
4. History of sleep apnea? Snoring? Bed wetting? C-PAP use?	Yes **O** No **O**	
5. Limited range of neck motion?	Yes **O** No **O**	
6. History of post-op nausea and vomiting?	Yes **O** No **O**	
1. History of reactive airway disease? Asthma? Wheezing?	Yes **O** No **O**	**Respiratory:**
2. Recent coughs, colds, or upper respiratory infections?	Yes **O** No **O**	
3. History of smoking?	Yes **O** No **O**	
4. Any other chronic airway disease? Bronchitis? Emphysema?	Yes **O** No **O**	
5. History of RSV?	Yes **O** No **O**	
1. History of congenital heart disease?	Yes **O** No **O**	**Cardiovascular:**
2. Heart valve problems?	Yes **O** No **O**	
3. History of irregular heart rhythms?	Yes **O** No **O**	
4. History of fainting or limitations to physical activity?	Yes **O** No **O**	
5. Can the patient walk up two flights of stairs w/o any issues?	Yes **O** No **O**	
6. Instances of shortness of breath or chest pain?	Yes **O** No **O**	
7. History of high blood pressure? Is it well-controlled?	Yes **O** No **O**	
1. Neurological deficits or developmental delays?	Yes **O** No **O**	**Central Nervous System/Syndromes:**
2. History of seizures?	Yes **O** No **O**	
3. Any clinically diagnosed syndromes?	Yes **O** No **O**	
4. History of depression? ADHD?	Yes **O** No **O**	
5. History of muscle weakness or muscular dystrophy?	Yes **O** No **O**	
6. Joint problems? Prior back surgeries?	Yes **O** No **O**	
1. History of kidney disease or difficulty urinating?	Yes **O** No **O**	**Endocrine/Renal:**
2. History of liver disease?	Yes **O** No **O**	
3. Diagnosis of diabetes? Is it well-controlled?	Yes **O** No **O**	
4. Any other endocrine disorders?	Yes **O** No **O**	
1. History of illicit drug use (i.e. heroin, cocaine, etc.)?	Yes **O** No **O**	**Other:**
2. Bleeding disorders? Anemia? Sickle cell anemia?	Yes **O** No **O**	
3. Recent use of blood thinners? Aspirin? Herbal supplements?	Yes **O** No **O**	
4. History of premature birth? How many weeks? NICU?	Yes **O** No **O**	
5. For females: any chance of pregnancy?	Yes **O** No **O**	
6. Any other health conditions not discussed above?	Yes **O** No **O**	

OFFICE USE ONLY: Medical consult requested due to patient being **O** High Risk (ASA III or Higher) or **O** Pediatric (12 Years and Under)

Physician's Note of Approval/Recommendations:	Physician Name:	Physician Signature:	Date: