PREOPERATIVE ASSESSMENT AND CALL SHEET

Name:	Home Phone #	Work Phone #
Scheduled Date & Time:	**Procedure:**	**Surgeon:**

Anesthesia Type: ☐ General ☐ Local/General ☐ Regional ☐ Local ☐ MAC

Sex: ☐ Male ☐ Female	Age:	Height:	Weight:	BMI if known:

Medical History—*Check if applicable and list any details/comments:*

☐ **High blood pressure** _____

☐ **Chest pain (angina)** _____

☐ **Heart attack** _____

☐ **Pacemaker &/or Defibrillator** _____

☐ **Heart murmur**—*if yes,* are antibiotics required prior to dental work?) _____

☐ **Fatigue climbing two flights of stairs or walking two blocks** _____

☐ **Irregular heart beat** _____

☐ **Asthma or Emphysema** _____

☐ **Bronchitis** _____

☐ **Productive cough/New cold** _____

☐ **Seasonal allergies** _____

☐ **Bleeding disorders/Anemia** _____

☐ **Sickle cell disease** _____

☐ **Stroke** _____

☐ **Psychiatric disorder** _____

☐ **Physical limitations** _____

☐ **Diabetes** _____

☐ **Thyroid disease** _____

☐ **Pain**—*if yes,* location and severity: _____

☐ **Cancer** _____

☐ **Kidney/Bladder disorder** _____

☐ **Hepatitis/Jaundice** _____

☐ **GERD/GI disorder** _____

☐ **HIV/AIDS** _____

☐ **Sleep apnea;** ***or any of the following:*** ☐ snore loudly at night ☐ feel tired or sleepy during daytime, ☐ stop breathing during sleep ☐ high blood pressure — ***if yes,*** ❑ **CPAP machine**

☐ ***For Females*—Last Menstrual Period:** _____

☐ **Other:** _____

_____

Surgical History: List with approximate dates

Anesthesia History: List any prior complications for yourself or family members

Social History:

☐ **Smoker**–*if yes,* packs per day & number of years:

☐ **Alcohol intake**–*if yes,* how much and how often:

☐ **Recreational drugs**–*if yes,* list which kind, how much and how often:

☐ **Advanced Directive**–*if yes,* please bring a copy

Notes:

Form completed by: _____ **Date:** _____ **Day of surgery instructions given:** ☐ Yes ☐ No

Updated by: _____ **Date:** _____ **Updated by:** _____ **Date:** _____

Updated by: _____ **Date:** _____ **Updated by:** _____ **Date:** _____

Updated by: _____ **Date:** _____ **Updated by:** _____ **Date:** _____

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PATIENT LABEL

PATIENT MEDICATIONS RECONCILIATION

Allergies	Reactions

Please list all medications, including prescriptions, over-the-counter and vitamins/herbal supplements:

Name of Medication	Dosage/ Frequency	Date of Last Dose						Date Discontinued

RN Signature: _____ **Date:** _____ **RN Signature:** _____ **Date:** _____

RN Signature: _____ **Date:** _____ **RN Signature:** _____ **Date:** _____

RN Signature: _____ **Date:** _____ **RN Signature:** _____ **Date:** _____

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PATIENT LABEL