

PATIENT HEALTH ASSESSMENT – PRE-ANESTHESIA CLINIC

Name: _____	DOB: _____		
Activity Assessment (Can the patient do the following?):	YES	NO	
Take care of self (e.g. eating, dressing, bathing, using the toilet)?	<input type="checkbox"/>	<input type="checkbox"/>	
Walk indoors?	<input type="checkbox"/>	<input type="checkbox"/>	
Walk 1-2 blocks on level ground?	<input type="checkbox"/>	<input type="checkbox"/>	
Climb a flight of stairs or walk up a hill?	<input type="checkbox"/>	<input type="checkbox"/>	
Run a short distance?	<input type="checkbox"/>	<input type="checkbox"/>	
Do light work around the house (e.g. dusting, washing dishes)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do moderate work around the house (e.g. vacuuming, sweeping floors, carrying groceries)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do heavy work around the house (e.g. scrubbing floors, lifting or moving heavy furniture)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do yardwork (e.g. raking leaves, weeding, pushing a lawnmower)?	<input type="checkbox"/>	<input type="checkbox"/>	
Have sexual relations?	<input type="checkbox"/>	<input type="checkbox"/>	
Participate in moderate recreational activities (e.g. golf, bowling, dancing, tennis, throwing a ball)?	<input type="checkbox"/>	<input type="checkbox"/>	
Participate in strenuous sports (e.g. swimming, cycling, football, basketball, skiing)?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had any of the following?	YES	NO	If YES, please give <u>details</u> and <u>dates</u>
Any surgery or procedure requiring sedation or general anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	
Any problems with anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Describe:
Family history of anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	
Struggle to get your jaw open more than 1.5 inches	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty lying flat and still for 30 minutes	<input type="checkbox"/>	<input type="checkbox"/>	
Any chest tightness / chest pain / heart pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> When walking <input type="checkbox"/> At rest <input type="checkbox"/> In last 3 months?
Fainting / near fainting episode in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure / hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had a stent placed in your heart	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had heart bypass surgery (CABG)?	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with your heart valves	<input type="checkbox"/>	<input type="checkbox"/>	
Any surgery to fix / replace a heart valve?	<input type="checkbox"/>	<input type="checkbox"/>	
History of heart failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have atrial fibrillation (A-Fib)?	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms?
Pacemaker or implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	
Born with any heart defects / abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	
Any other heart conditions not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	
Would you accept blood transfusion if needed?	<input type="checkbox"/>	<input type="checkbox"/>	

PLACE PATIENT LABEL HERE

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Have you ever had any of the following?	YES	NO	If YES, please give <u>details</u> and <u>dates</u>
Recent trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> With activity <input type="checkbox"/> at rest
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the last month?
Daily cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bring up phlegm daily
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> History of ER visits or hospitalization
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Using CPAP/BiPAP
Home oxygen	<input type="checkbox"/>	<input type="checkbox"/>	How much (e.g. L/min)?
Pulmonary artery hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
COPD or emphysema	<input type="checkbox"/>	<input type="checkbox"/>	
Acid reflux or heart burn	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> With ascites (abdominal fluid accumulation)
Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> on insulin	<input type="checkbox"/>	<input type="checkbox"/>	Last A1C:
Thyroid Issues <input type="checkbox"/> Goiter <input type="checkbox"/> Hypo (low) <input type="checkbox"/> Hyper (high)	<input type="checkbox"/>	<input type="checkbox"/>	
Low kidney function / kidney disease (CKD or ESRD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hemodialysis? Which days:
Excessive bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clots in legs / DVT or lungs / PE	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Type and treatment:
Current skin infection or open wounds	<input type="checkbox"/>	<input type="checkbox"/>	
History of MRSA infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Treated?
Autoimmune disease or other immune disease	<input type="checkbox"/>	<input type="checkbox"/>	
Steroids, prednisone or immunotherapy (including IV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the last year?
HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
History of an organ transplant	<input type="checkbox"/>	<input type="checkbox"/>	Which organ?
Arthritis <input type="checkbox"/> with neck involvement	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke or TIA <input type="checkbox"/> remaining symptoms	<input type="checkbox"/>	<input type="checkbox"/>	When?
Neurologic disease, causing weakness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	When was last one?
Significant memory loss / dementia	<input type="checkbox"/>	<input type="checkbox"/>	
Prescription pain medications more than 2 months	<input type="checkbox"/>	<input type="checkbox"/>	
Use a pain pump or implant / stimulator	<input type="checkbox"/>	<input type="checkbox"/>	What type?
Methadone / suboxone / buprenorphine / naltrexone	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently unhoused or homeless?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you blind?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a physical disability?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you need help with self-care at home?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you need help with your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	

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