Documenting the Standard of Care: The Anesthesia Record

Currently, there is tremendous variation in the type of information found in the anesthesia record and in the way it is entered. At times this can make it difficult for professionals outside a specific institution to decipher records.

In the past, monitoring consisted of a finger on the pulse, a blood pressure cuff, and an “educated hand on the bag,” and the records reflected that same simplicity. But advances in anesthesia technology have greatly increased the amount of information available to CRNAs about the course of an anesthetic. Accordingly, anesthetic records should reflect all the information used. This document is intended to assist CRNAs and others who wish to update the record format they presently use.

In preparing this document, the American Association of Nurse Anesthetists (AANA) Practice Committee looked at the wide variety of information relevant to anesthesia care, including preanesthesia assessment, anesthesia procedural data, and postanesthesia follow-up. The cases involved ranged from a simple monitored anesthetic with no sedation, to multiple organ transplants with invasive monitoring and multiple providers. The amount of information generated by these types of cases varies significantly.

Regardless of the wide range of cases, there is a basic core of information that must be documented. Patient identification, provider information, equipment checks, minimal monitors, techniques, medications, intake and output, and procedural data are all part of the basic data that is necessary for every anesthesia record. A record of any parameters monitored during the anesthetic should also be part of the basic data. The amount of additional information needed is dictated by the type of anesthetic, the procedure, and the patient’s condition.

Preanesthesia Evaluation and Informed Consent
A thorough evaluation of the patient by an anesthesia professional is mandatory prior to the administration of anesthesia. In addition to a review of systems and records, such an evaluation should contain personal communications; physical assessment, when indicated; and evidence that informed consent for the anesthetic has been obtained.

Documentation of both the preanesthetic evaluation and the informed consent for anesthesia should be present in the patient’s chart. Often, a preanesthetic evaluation appears in a special part of the anesthesia record (usually on the back); sometimes, a separate form is used. Notations also may be made in dictated or written narrative form for inclusion in the progress notes in the patient’s chart. Informed consent for anesthesia may be part of the surgical/procedural consent form, along with a written notation in the progress notes. In some instances, a separate anesthesia consent form may be used. Increasingly, an additional consent form, authorizing the administration of blood or blood products, is obtained.

The topic of informed consent is discussed more fully in the AANA document titled, Informed Consent in Anesthesia.

Anesthesia Care During the Procedure
Anesthesia care normally is documented in a graphic anesthesia record, which includes a sequence of entries reflecting the anesthesia care given, the drugs and fluids administered, and the patient’s responses to the care. Some of this information may be recorded by the operating room nurse in intraoperative
nursing notes that cover patient positioning, restraints, safety straps, padding, grounding pads, tourniquets, warming blankets, and other aspects of care.

The design of an anesthesia record should allow for a sequential recording of information and serve as a reminder of the items to be recorded. The graphic charting area of the record should be composed of a grid on which vital signs, as well as drugs and fluids administered, are recorded. Space for recording monitoring parameters is usually provided as well. The grid—perhaps the entire form—should be printed in color ink or screened to a light gray to make it easier to record (and subsequently read) the symbols commonly used for vital signs.

**Immediate Postanesthesia Care**

Postanesthesia care can be divided into two parts. The initial portion is usually provided in a postanesthesia care unit (PACU) or recovery room. Normally, the provider who administered the anesthetic is not directly involved in caring for the patient during recovery from anesthesia. The care of the patient is customarily turned over to other personnel, such as registered nurses and other staff. This care may be supervised by a physician or by an anesthesia professional. In large institutions, a full-time anesthesia professional often is available at all times to respond to patients’ needs.

The care the patient receives in the PACU is usually documented in a special graphic form which allows for frequent chronological charting of vital signs data. These data may include intake, output, allergies, postoperative problems, treatments and medications, as well as other details regarding care during the postanesthesia recovery period.

The other component of postanesthesia care comes from the anesthesia professional, who supplies a postanesthesia evaluation of the patient encompassing recovery from anesthesia, evaluation, treatment, and follow-up of possible anesthesia-related complications. This evaluation is often made at the end of the day or on the following morning for inpatients and by telephone for outpatients.

Some anesthesia records incorporate three areas of anesthesia care in one form: 1) the preanesthesia evaluation, 2) the record of care during the procedure, and 3) the postanesthesia evaluation. The sample forms that are included in this document were designed so that the preanesthesia and postanesthesia portions could be printed on the back of the procedural record.

**Categories of Patient Information**

In reviewing charts and talking with practitioners, it is clear that some items entered in the anesthesia record are included out of habit, because of institutional policy, or simply as a result of using poor or outdated forms. In creating the forms in this document, the AANA Practice Committee organized information that is generally recognized as important into three broad categories:

1. Information to be contained in the anesthesia record.
2. Information to be immediately available in the patient’s operative chart.

**Information to Be Contained in the Anesthesia Record**

Exhibit I shows a core of information that should be contained in all records. The amount of additional information required will vary with the type of case and the status of the patient.

**Information to Be Immediately Available in the Patient’s Operative Chart**

Exhibit II contains information that should be present in the chart at the time of surgery or recorded during the procedure. In some settings, this information may appear in the anesthesia record or a separate form, such as the operating room nurse’s notes. Some institutions use a separate form for the
preanesthesia evaluation; it may be found on the back of the anesthesia record or on a separate page or pages.

While information such as identification of the patient and procedure and protective measures used (safety straps, positioning, padding, etc.) may be included in the operating room nurse’s notes, it should also be recorded in the patient’s chart. Because transfer of care information is very important to the anesthetist, in some instances a separate form (i.e., on the recovery record) may be most suitable for documenting this information.

**Anesthesia-Related Information to Appear on the Patient’s Hospital Chart**

Exhibit III displays information which is generally recorded in the hospital chart. The anesthesia record cannot be expected to be the sole source of information in every circumstance. For example, unanticipated cardiac arrest and resulting resuscitation should be noted in the anesthesia record, accompanied by a written narrative account. Anesthesia professionals should not feel they are limited to the anesthesia record, no matter how inclusive it may be.

**Types of Anesthesia Records**

Anesthesia is provided in numerous practice settings. The types of care delivered in these settings may be straightforward or quite complex. Obstetric anesthesia care may also be a part of the practice. Consequently, a single anesthesia record may not be adequate for such a broad range of care. In recognition of the variety of care given and the resultant differences in information generated, the AANA Practice Committee has designed three basic chart formats: the short form anesthesia record, the complex case anesthesia record, and the preanesthesia evaluation form (also see the “Resources” section of the *Professional Practice Manual for the Certified Registered Nurse Anesthetist*).

**Short Form Anesthesia Record**

This type of record contains all the information that is included in the complex case anesthesia record in check-box format. However, it has a larger graphic charting area, since it covers a shorter period of time. Because more space is available, the areas for recording waste of controlled substances and for remarks are larger than in the complex case form. It is anticipated that this form should be well-suited for outpatient surgery, office anesthesia, and monitored anesthesia care. It is, however, sufficiently comprehensive that it could be used for complex regional or general anesthetics lasting up to three and one-half hours. The form provides space for page numbering, should additional forms be required for a single case.

**Complex Case Anesthesia Record**

This form differs from the short form because the area for documenting waste of controlled substances appears at the top of the form in place of the recovery notes. This type of record is particularly well-suited to lengthy cases, providing space to chart comprehensive monitoring modalities over a five-hour period. The only other significant difference is the amount of space allowed for remarks. This form is useful for complex anesthetics delivered in inpatient hospital settings.

**Preanesthesia Evaluation Form**

This form provides a place to record preanesthesia evaluation information. It is designed to be printed on the back of the anesthesia record. The postanesthesia note section can be replaced by space for additional intraoperative notes or left blank for the patient identification stamp, if the form is used separately.

The items on the left side of the systems review area are meant to serve as reminders and are not intended to be used as a checklist or an all-inclusive list of diseases or conditions that might exist in a given patient.
These model forms have not been copyrighted and healthcare providers and institutions are welcome to use all or parts of them in their own settings at no cost. They can be used as is or serve as the basis for the design of a new form. We advise potential users to consult local legal counsel before adapting the forms and to seek permission from the appropriate “forms” committee or administrator of the hospital or institution in which you plan to use them. The AANA does not warrant the forms as being free of legal defects, and providers who elect to use them do so at their own risk.

**Quality Management**
The designs of all the forms were strongly influenced by the current emphasis on quality assurance and risk management. This is especially true of the anesthesia records. Using a check-box format not only indicates whether a special monitor was available, a certain regional technique was employed, or which patient safety devices were used, but also serves as a reminder of items to be recorded.

These forms have been reviewed by several institutional quality assurance committees and found to be acceptable for recording necessary information. The size of the remarks area has been reduced when compared with other forms, because only pertinent information must be written. Most of the routine data noted during induction and maintenance of anesthesia can be recorded in the check-box format.

**Summary**
The AANA Practice Committee urges individuals to feel free to select the format best suited to their practice, to alter the form(s) to meet institutional needs, and to use them in their practice. The importance of maintaining good, comprehensive anesthesia records is well-established. Second only to the actual care of the patient, the anesthesia record is a vital component of the professional services rendered. These forms meet the need to organize the technical information generated into a concise, workable format. They serve to make the record informative, legible, and useful.

**Exhibit I: Information to be contained in the Anesthesia Record**

<table>
<thead>
<tr>
<th>A. Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name</td>
</tr>
<tr>
<td>2. Age</td>
</tr>
<tr>
<td>3. Identification number</td>
</tr>
<tr>
<td>4. Sex</td>
</tr>
<tr>
<td>5. Weight</td>
</tr>
<tr>
<td>6. Height</td>
</tr>
<tr>
<td>7. Allergies</td>
</tr>
<tr>
<td>8. Physical status</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary anesthetist</td>
</tr>
<tr>
<td>2. Secondary anesthetist, if any</td>
</tr>
<tr>
<td>3. Relief provider, times of relief, credentials</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Anesthesia Equipment - Safety Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Equipment functioning</td>
</tr>
<tr>
<td>2. Check performed just prior to case</td>
</tr>
<tr>
<td>3. If indicated, list equipment numbers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Monitors to be Used - Minimal Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Electrocardiogram</td>
</tr>
<tr>
<td>2. Blood pressure</td>
</tr>
<tr>
<td>3. Precordial stethoscope</td>
</tr>
<tr>
<td>4. Pulse oximetry</td>
</tr>
<tr>
<td>5. Oxygen analyzer</td>
</tr>
<tr>
<td>6. End tidal carbon dioxide</td>
</tr>
</tbody>
</table>
E. Monitoring Information - Minimal Standard - On Graphic Display
1. Electrocardiogram
2. Blood pressure
3. Heart rate
4. Ventilation status
5. Oxygen saturation

F. Additional Monitors Indicated for Selected Cases
1. Esophageal stethoscope
2. Thermometer
3. Nerve stimulators
4. Respirometers
5. Arterial catheters
6. Central lines/pulmonary artery catheters
7. Mass spectrometry
8. Electroencephalography
9. Other

G. Monitoring Information Indicated by Type of Procedure - Graphic Recording or Other
Continuous Trending
1. Temperature
2. Inspired oxygen
3. End tidal CO₂ level
4. Ventilator information
   a. Tidal/minute volume
   b. Peak inspiratory pressure
   c. Rate
5. Central line pressure readings
   a. Pulmonary artery
   b. Central venous pressure
6. Electroencephalographic changes
7. Other readings as indicated, i.e., degree of muscle paralysis

H. Airway Management Techniques - Indicated on Anesthesia Record
1. Mask
2. Intubation
   a. Oral, nasal, double lumen
   b. Endotracheal tube size and type
   c. Cuff - absent, present
   d. Laryngoscope - blade type and size
   e. Performed awake or asleep
   f. Technique: direct vision, blind, fiberoptic
3. Difficulties with intubation
4. Assessment of tube placement
   a. Breath sounds checked
   b. Presence of EtCO₂ readings
   c. How secured and depth (cm) at lips/teeth
5. Cuff inflation-air, saline, amount/pressure
6. Times of intubation/extubation
7. Ventilation parameters
   a. Respiratory rate
   b. Tidal/minute volumes
   c. Peak inspiratory pressures
   d. Positive end expiratory pressure
8. Artificial airway
   a. Oral, nasal

I. Medications Administered (anesthetics, adjuncts, antibiotics, etc.)
   1. Names
   2. Routes
   3. Amounts/concentrations
   4. Times - use of graphic or continuous flow charting most desirable for anesthetic drugs
   5. Totals, when indicated
   6. Unusual patient responses (i.e., rash after antibiotics)

J. Techniques Used
   1. Type of anesthesia
      a. General, mask or endotracheal
      b. Regional
      c. Monitored care
      d. Other
   2. Induction
      a. Inhalation
      b. Intravenous
      c. Rectal
      d. Intramuscular
   3. Maintenance, general anesthetics
      a. Circle system
      b. Non-rebreathing
   4. Intravenous routes established
      a. Location of IV(s), size and patency
   5. Monitoring lines placed
      a. Technique, equipment, problems
   6. Regional
      a. Specific technique, equipment, problems, levels achieved, results

K. Intake
   1. Crystalloid
   2. Blood/blood products
   3. Colloids
   4. Volume expanders
   5. Others

L. Output - When Indicated, Should be on Record
   1. Urine
   2. Blood loss
   3. Nasogastric (may be on operative record)
   4. Other, i.e., ascites could be on the anesthesia record or on the operating room nurse’s record

M. Procedural Data
   1. Actual operative procedure performed
   2. Date
   3. Times of starting and stopping anesthesia using 24-hour clock
   4. Times of starting and stopping procedure

N. Patient Protection
   1. Position, position changes
   2. Eye protection
   3. Securing of monitoring lines
   4. Other, as indicated
Exhibit II - Information to be Immediately Available in the Patient’s Operative Chart

A. Preanesthesia Assessment
   1. Review of systems
   2. Current diagnosis
   3. Pertinent lab data
   4. Pertinent physical examination findings
   5. Allergies/sensitivities
   6. Airway assessment
      a. Anatomy
      b. Dentures/teeth
      c. Previous problems under anesthesia
   7. Surgical/anesthesia history
   8. Medication history
   9. Social history
      a. Smoking
      b. ETOH use
      c. Drug use
   10. Family problems with anesthesia
   11. Other
      a. Transfusion history
      b. Disabilities
      c. Communication problems
      d. Prosthetics, etc.

B. Physical Status Assigned

C. Patient Interview Accomplished
   1. Risks/benefits discussed
   2. Anesthesia plan discussed
   3. Patient consent obtained

D. Patient and Procedure Identification
   1. Surgery consent form signed and dated
   2. Anesthesia consent form signed and dated
   3. Patient identified
   4. Proposed procedure
   5. Surgical site affirmed

E. Patient Protection (may be on operating room nurse’s record)
   1. Padding of pressure points created by surgical position requirements
   2. Special anatomical considerations
   3. Safety strap
   4. Tourniquets, placement and times
   5. Grounding plate, site

F. Transfer of Care Information
   1. To what unit (ICU, PACU, etc.)?
   2. Report given on
      a. Patient identification, name, age
      b. Allergies
      c. Anesthetic type, drugs used
      d. Blood/fluid status
      e. Complications, if any
      f. Procedure performed
      g. Vital signs
      h. Pre-existing conditions/medications
i. Condition
j. Airway status/oxygen requirements

**Exhibit III - Anesthesia Related Information to Appear in the Patient’s Hospital Chart**

A. Postanesthesia Note
   1. Time and date of visit
   2. Complications, if any
   3. General status
      a. Systems reviewed should reflect care given
   4. Signature

B. Additional Comments (May be in anesthesia record if space allows, or in progress notes. Should be indexed to events on record, if indicated.)
   1. Unanticipated patient responses
   2. Emergency measures
   3. Any deviations from standard of care and their rationale
## ANESTHESIA RECORD

### TIME
- **Oxygen (L/min):** [Observered]
- **EML** (mL): [Observered]
- **EKG:** [Observered]
- **O₂ Saturation:** [Observered]
- **End Tidal CO₂:** [Observered]
- **Temp:** °C or °F

### FLUIDS/AGENTS
- **Urine:** [Observered] mL
- **EML:** [Observered] mL
- **IVs:** [Observered]
- **PA Line:** [Observered]
- **CVP:** [Observered]
- **Armband Restraints:** [Observered]
- **Eye Care:** [Observered]

### PATIENT SAFETY
- **Safety Belt On:** [Observered]
- **Arms Tucked:** [Observered]
- **Nasal Cannula:** [Observered]
- **Ointment:** [Observered]
- **Other:** [Observered]

### MONITORS AND EQUIPMENT
- **Steth:** [Observered]
- **Continuous EKG:** [Observered]
- **Pulse Oximeter:** [Observered]
- **End tidal CO₂:** [Observered]
- **Blood Gas Analyzer:** [Observered]
- **Airway Humidifier:** [Observered]
- **Fluid Warmer:** [Observered]
- **NG/OG Tube:** [Observered]
- **Tape:** [Observered]

### FLUIDS/AGENTS
- **Baseline Values:** [Observered]
- **B/P:** [Observered]
- **P:** [Observered]
- **R:** [Observered]
- **Total Volume:** [Observered]
- **Resp Rate:** [Observered]
- **Peak Pressure:** [Observered]

### MONITORS AND EQUIPMENT
- **CVP:** [Observered]
- **Position:** [Observered]
- **Cuff Pressure:** [Observered]
- **PEEP:** [Observered]
- **Aldrete Scale:** [Observered]
- **Tape:** [Observered]

### PATIENT IDENTIFICATION
- **Anesthesia Provider:** [Observered]

### ANESTHESIAT TECHNIQUE
- **Intubation:** [Observered]
- **Stylet Used:** [Observered]
- **Nasal Tube Size:** [Observered]
- **Intravenous:** [Observered]
- **Inhalation:** [Observered]
- **Intramuscular:** [Observered]
- **Regional:** [Observered]
- **Axillary:** [Observered]
- **Blade:** [Observered]
- **Fiber Optic:** [Observered]
- **Blind:** [Observered]
- **Armed Blind:** [Observered]
- **Laryngoscope:** [Observered]
- **Reverse Traction:** [Observered]
- **ET CO₂:** [Observered]
- **Secured at cm:** [Observered]
- **RAE Direct:** [Observered]
- **See Remarks:** [Observered]

### FLUID TOTALS
- **Crystalloid:** [Observered]
- **EBL:** [Observered]
- **Urine:** [Observered]

### PATIENT SAFETY
- **NPO Since:** [Observered]
- **Rectal:** [Observered]
- **Magill's:** [Observered]
- **Ketamine:** [Observered]
- **Atropine:** [Observered]
- **Oxigen:** [Observered]
- **Oxygent:** [Observered]
- **Nasal Oxygen:** [Observered]

### MONITORS AND EQUIPMENT
- **Position:** [Observered]
- **EEG:** [Observered]
- **Attempts x:** [Observered]
- **Bier Block:** [Observered]
- **Axillary Block:** [Observered]
- **Epidural:** [Observered]
- **Art Line:** [Observered]
- **Local Anesthesia:** [Observered]
- **End Tidal CO₂:** [Observered]
- **Temp:** °C or °F
- **Nerve Simulator:** [Observered]
- **Prep:** [Observered]
- **Spinal:** [Observered]
- **Site:** [Observered]
- **Needle:** [Observered]
- **Catheter:** [Observered]
- **IV(s):** [Observered]
- **PA Line:** [Observered]
- **CVP:** [Observered]
- **Level:** [Observered]
- **Unsufflated:** [Observered]
- **Leaked at cm H2O:** [Observered]
- **B/P:** [Observered]
- **Precordial:** [Observered]
- **Tracheostomy:** [Observered]
- **Via Tracheostomy:** [Observered]
- **Simple O₂ Mask:** [Observered]

### PATIENT IDENTIFICATION
- **Witness:** [Observered]

### ANESTHESIA PROVIDER
- **Drug:** [Observered]
- **Issued:** [Observered]
- **Used:** [Observered]
- **Returned:** [Observered]
- **Provider:** [Observered]
### ANESTHESIA RECORD

**Date**: [Insert Date]  
**OR No.**: [Insert OR Number]  
**Page of**: [Insert Page Number]  
**Surgeon(s)**: [Insert Surgeons' Names]

#### PRE-PROCEDURE
- [ ] Identifed  
- [ ] ID Band  
- [ ] Questioning  
- [ ] Chart Reviewed  
- [ ] Permit Signed  
- [ ] NPO Since  
- [ ] Pre-anesthetic State:  
  - [ ] Calm  
  - [ ] Awake  
  - [ ] Not Ambulatory  
- [ ] Pain  
- [ ] Complications  
- [ ] Allergies  
- [ ] Surgery Location

#### PATIENT SAFETY
- [ ] Anes. Machine #:  
- [ ] Safety Belt On  
- [ ] Ambulance Access  
- [ ] Eye Care:  
  - [ ] Ointment  
  - [ ] Sedative  
- [ ] Taped  
- [ ] Pads  
- [ ] Goggles

#### MONITORS AND EQUIPMENT
- [ ] Stethoscope:  
  - [ } Precord  
  - [ ] Echocardiogram  
- [ ] Non-Invasive B/P:  
  - [ ] Left  
  - [ ] Right  
- [ ] Continuous EKG  
  - [ ] V Lead EKG  
- [ ] Pulse Oximeter  
  - [ ] Oxygen Sensor  
- [ ] End tidal CO₂  
  - [ ] Gas Analyzer  
- [ ] Temp:  
  - [ ] Nerve Stimulator  
- [ ] Warming Blanket  
  - [ ] EEG  
  - [ ] Doppler  
- [ ] Monitoring:  
  - [ ] NIBP  
  - [ ] Pulse  
- [ ] Other:  
  - [ ] M.A.C.

#### ANESTHETIC TECHNIQUE
- [ ] General:  
  - [ ] Pre-Oxygenation  
  - [ ] L.T.A.  
  - [ ] Rapid Sequence  
  - [ ] Orotracheal Intubation  
- [ ] Intravenous:  
  - [ ] Inhalation  
  - [ ] Intravenous  
  - [ ] Rectal  
- [ ] Regional:  
  - [ ] Spinal  
  - [ ] Epidural  
  - [ ] Axillary  
  - [ ] Bier Block  
  - [ ] Ankle Block

#### AIRWAY MANAGEMENT
- [ ] Intubation:  
  - [ ] Oral  
  - [ ] Tube size  
- [ ] Magill's:  
  - [ ] Direct  
  - [ ] RA E  
- [ ] Fiber optic  
  - [ ] Blind  
  - [ ] Armored

#### LOCATION
- [ ] Time
- [ ] Room

#### CONTROLLED DRUGS
- [ ] Drug  
- [ ] Used  
- [ ] Destroyed  
- [ ] Returned

#### TIME
- [ ] Oxygen (mmHg)
- [ ] N₂O (mmHg)
- [ ] Air (mmHg)

#### FLUIDS
- [ ] Fluids
- [ ] Urine (ml)
- [ ] EBL (ml)

#### EKG
- [ ] %O₂ (Inpired)
- [ ] SpO₂ (Saturation)
- [ ] End tidal CO₂
- [ ] Temp:  
  - [ ] °C
  - [ ] °F

#### BASELINE VALUES
- [ ] B/P:  
  - [ ] 200
  - [ ] 180
  - [ ] 160
  - [ ] 140
  - [ ] 120
  - [ ] 100
  - [ ] 80
  - [ ] 60
  - [ ] 40
  - [ ] 20

#### VITAL SIGNS
- [ ] P:  
  - [ ] 200
  - [ ] 180
  - [ ] 160
  - [ ] 140
  - [ ] 120
  - [ ] 100
  - [ ] 80
  - [ ] 60
  - [ ] 40
  - [ ] 20

#### TIDAL VOLUME
- [ ] Respiratory Rate
- [ ] Peak Pressure
- [ ] PEEP

#### REMARKS
- [ ] Position  
- [ ] Anesthesia Provider

**P91-2**
### Preanesthesia Evaluation

<table>
<thead>
<tr>
<th>Proposed Procedure</th>
<th>Age</th>
<th>Sex</th>
<th>M</th>
<th>F</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>in/cm</td>
<td>lb/kg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-Procedure Vital Signs B/P</th>
<th>P</th>
<th>R</th>
<th>T</th>
<th>None</th>
<th>Current Medications</th>
<th>None</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Family History of Anesthesia Complications</th>
<th>None</th>
<th>Allergies</th>
<th>None</th>
</tr>
</thead>
</table>

#### AIRWAY / TEETH / HEAD & NECK

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>VNL</th>
<th>COMMENTS</th>
<th>DIAGNOSTIC STUDIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESPIRATORY</td>
<td>Asthma</td>
<td>Productive Cough</td>
<td>Tobacco Use: Yes No Packs / Day for Years</td>
</tr>
<tr>
<td></td>
<td>COPD</td>
<td>SOB</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dyspnea</td>
<td>Tachypnea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopnea</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARDIOVASCULAR</td>
<td>Arrhythmia</td>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Angina</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aortic Stenosis</td>
<td>Murmur</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHF</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dizziness</td>
<td>Palpitations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exercise Tolerance</td>
<td>Varicose Veins</td>
<td></td>
</tr>
</tbody>
</table>

#### HEPATO / GASTROINTESTINAL

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>VNL</th>
<th>COMMENTS</th>
<th>DIAGNOSTIC STUDIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Obstruction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cirrhosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis / Jaundice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hairy Hara, Reflux</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuropathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### NEURO / MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>VNL</th>
<th>COMMENTS</th>
<th>DIAGNOSTIC STUDIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Muscle Weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Problems</td>
<td>Neuromuscular Ds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVA / Stroke / TIA</td>
<td>Paralysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CJD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches / ICP</td>
<td>Syncope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of Consciousness</td>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### RENAL / ENDOCRINE

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>VNL</th>
<th>COMMENTS</th>
<th>DIAGNOSTIC STUDIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Failure / Dialysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary Retention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Loss / Gain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### OTHER

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>VNL</th>
<th>COMMENTS</th>
<th>DIAGNOSTIC STUDIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Immunosuppressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding tendencies</td>
<td>Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Skeletal Tumor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Radiation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td>Transfusion History</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Problem List / Diagnoses

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

#### Physical Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Signed</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

#### Postanesthesia Note

- **Planned Anesthesia / Special Monitors**
  - [ ] 6

- **Pre-Anesthesia Medications Ordered**
  - [ ] 7

- **Evaluator Signature**
  - [ ] 8
  - Date
  - Time

#### Patient Identification

- **Date**
- **Time**