Mackinaw Surgery Center
5400 Mackinaw Rd
Saginaw, MI 48604

ASSESSMENT FLOWSHEET

Patient ID

Patient Name:_____Height_____Weight_____lbs_____Kg, BMI_____
Surgery/Procedure:_____
History of Surgical Procedures: ☐ T&A ☐ Ear tubes ☐ Appendectomy ☐ Hernia ☐ Gallbladder ☐ Hysterectomy ☐ Scopes:_____
_____
Primary Care Physician_____Cardiologist_____
Allergies & Reactions ☐ Latex ☐ Tape ☐ Shellfish ☐ Eggs ☐ Peanuts
_____
Drug Allergies & Reactions ☐ No Known Allergies (NKA)
_____

NEUROLOGICAL	YES	NO
Seizures	☐	☐
Stroke/TIA/Mini Stroke	☐	☐
Numbness or Tingling	☐	☐
Fainting spells	☐	☐
Neuromuscular diseases	☐	☐
Anxiety	☐	☐
Pain: Location_____(0-10)	☐	☐
Description_____Acceptable_____		
Comments:_____		

ENT	YES	NO
Loose, Chipped, or Missing Teeth	☐	☐
Dentures or Partials	☐	☐
Problems Opening or Closing your mouth	☐	☐
Difficulty moving your neck	☐	☐
Comments:_____		
_____		

LUNGS	YES	NO
*****Do you require supplemental oxygen 24 hours a day?	☐	☐
Asthma, Cough, Cold, or Wheezing	☐	☐
Shortness of breath	☐	☐
COPD	☐	☐
Sleep Apnea; use CPAP/BiPAP Machine	☐	☐
Smoker: amt:_____ yrs._____	☐	☐
Comments:_____		
_____		

CARDIAC	YES	NO
*****Do you get short of breath or have chest pains when; climbing a flight of stairs; doing light housework or other activities of daily living?	☐	☐
*****Have you been hospitalized in the last 3 months for congestive heart failure, heart Attack or an angioplasty?	☐	☐
*****Chest pain or Angina (related to your heart)	☐	☐
Has there been a decrease in activity in the last 3 months r/t your heart?	☐	☐
Heart surgery; bypass or valve replacement	☐	☐
Arrhythmias, IED implanted electrical device	☐	☐
Heart Cath., Stents, Stress Test	☐	☐
High blood pressure	☐	☐
Comments:_____		
_____		

ENDOCRINE/METABOLIC	YES	NO
*****Kidney problems or Dialysis	☐	☐
Diabetes Type_____	☐	☐
Thyroid disease	☐	☐
Comments:_____		
_____		

MUSCULOSKELETAL	YES	NO
Arthritis	☐	☐
Muscle disease/Muscular Dystrophy	☐	☐
Limitation in movement	☐	☐
Hx of DVT, PE, blood clots/disorder	☐	☐
Comments:_____		

COMMUNICABLE DISEASES	YES	NO
Do you have any signs of infection; fever; open wounds; recent flu or upper respiratory infection?	☐	☐
Do you have difficulty fighting off infections due to a chronic condition?	☐	☐
Are you being treated for any contagious diseases?	☐	☐
*****MRSA	☐	☐
Tuberculosis	☐	☐
Hepatitis What type_____	☐	☐
Comments:_____		
_____		

ANESTHESIA	YES	NO
*Difficult Intubation	☐	☐
Nausea or vomiting after receiving anesthesia	☐	☐
*Family/Personal History of Malignant Hyperthermia	☐	☐
Comments:_____		
_____		

ALCOHOL USE	YES	NO
Frequency:_____	☐	☐
Substance Abuse	☐	☐
Comments:_____		
_____		

GASTROINTESTINAL	YES	NO
GERD or Reflux	☐	☐
Hiatal Hernia or Ulcer	☐	☐
Cirrhosis	☐	☐
Comments:_____		

OTHER	YES	NO
Bleeding, Anemia, or Sickle Cell Disease	☐	☐
Are you Pregnant?	☐	☐
Last Menstrual Cycle_____	☐ N/A	
Steroid use in the last 12 months	☐	☐
Comments:_____		

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Please list all medications you are currently taking, including over the counter meds, vitamins, supplements, herbal products and occasionally needed medications

Medication Name	Dose	Time/ Day	Reason for Med	Resume Y N	Medication Name	Dose	Time/ Day	Reason for Med	Resume Y N
***Example**: Vasotec*	*10mg*	*2*	*Blood Pressure*	☐ ☐					☐ ☐
				☐ ☐					☐ ☐
				☐ ☐					☐ ☐
				☐ ☐					☐ ☐
				☐ ☐					☐ ☐
				☐ ☐					☐ ☐
				☐ ☐					☐ ☐
				☐ ☐					☐ ☐
				☐ ☐					☐ ☐

Medication Hx Provided by: ☐ Patient ☐ Family ☐ See Medication Reconciliation Continuation Form

☐ Contact your family Physician regarding all previous medications * Advised to take A.M. of procedure (i.e., heart & B/P meds)

Pre-op Instructions

Reviewed with patient/caretaker/driver

Arrival Date & Time (approximate)_____

NPO 6 hrs before you arrive for solids & 4 hrs for liquids, NO gum or hard candy

Medication to take morning of surgery with sip of water, See Med Rec. Form

Shower with antimicrobial soap morning of surgery

No shaving/depilatory cream on surgery site 24 hrs prior

Bring photo ID, insurance cards

Bring inhalers, Insulin

Limit Visitors to 1- 2

Dress Comfortably, No jewelry, make up or valuables

remove contact lenses and body piercing(s)

Directions to facility offered

Responsible person to drive home

Comfort measure for peds (Bottle / Pacifier/favorite toy)

Questions answered, understanding verbalized ☐ Yes ☐ No

PAT RN Signature:_____ Date_____Notes:_____

Pre-op Vital Sign	B/P	P	Resp	Temp	SpO2	NPO since:
ASA Rating	1 2 3 4 5	☐ Potential Difficult Intubation			Urine HCG ☐ N/A ☐ Negative ☐ Positive	
Mallampati	I II III IV	Poor Dentition ☐ Yes ☐ No			☐ FBS_____ ☐ Motion Sickness	

Anesthesia Plan, risks, and benefits discussed with:☐ Patient ☐ Parent ☐ Guardian

Anesthesia Plan: MAC GA Block SP EP

Systemic Review	**Unremarkable**	**Abnormal Findings**	
Mental Status (Orientated x 3)	☐	☐ confused ☐ apprehensive ☐ uncooperative	☐ Hearing Aids Removed ☐ Yes ☐ No
Nervous System	☐		
Cardiovascular	☐	☐ No ☐ Yes risk of >500ml blood loss (7ml/Kg in children)	☐ Glasses Removed ☐ Yes ☐ No
Respiratory	☐	☐ labored	
Gastrointestinal	☐	☐ BS absent	Dentures Removed ☐ Yes ☐ No
Genitourinary	☐		Fleets ☐ Yes ☐ N/A
Musculoskeletal	☐		Bowel Prep ☐ Yes ☐ N/A
Other (skin)	☐	☐ cool ☐ moist ☐ pale	Good Results ☐ Yes ☐ No
Physical Exam	**Unremarkable**	**Abnormal Findings**	
HEENT	☐		
Heart	☐	☐ +1< Radial ☐ +1<Pedal	
Lungs	☐	☐ diminished ☐ rhonci ☐ wheezes	
Abdomen	☐	☐ rounded ☐ firm	☐ Feels safe in home
Other / General Condition	☐		☐ No Signs of patient neglect

Reviewed By:

Pre-op Nurse_____Time:_____

Endo/OR Nurse (if applicable)_____Time:_____

CRNA_____Time:_____

Anesthesiologist_____Time:_____