

**Patient name** \_\_\_\_\_ **card No** \_\_\_\_\_ **Address** \_\_\_\_\_  
**Preanesthetic evaluation form**      **Age** \_\_\_\_\_ **yrs**      **sex:** ☐ **male**  
**female**

|                                                                                                                                                                                                                                                                             |                          |                                                                                                                                                                                                                                           |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Diagnosis _____                                                                                                                                                                                                                                                             |                          | Weight _____ Kg height _____ m <b>ASA</b> 1 2 3                                                                                                                                                                                           |                          |
| Planned procedure                                                                                                                                                                                                                                                           |                          | 5 6 E                                                                                                                                                                                                                                     |                          |
| Medical history                                                                                                                                                                                                                                                             |                          | Vital signs: BP _____ PR _____ RR _____<br>T° _____                                                                                                                                                                                       |                          |
| Previous surgical/anesthesia hx                                                                                                                                                                                                                                             |                          | Current medication                                                                                                                                                                                                                        |                          |
| <b>Family hx of anesthesia complications</b><br>None <input type="checkbox"/> prolonged par <input type="checkbox"/> sis <input type="checkbox"/> MH<br>other _____                                                                                                         |                          | Allergic/Drug Reactions                                                                                                                                                                                                                   |                          |
| <b>INTUBATION ASSESSMENT</b>                                                                                                                                                                                                                                                |                          | Diagnostic and lab studies                                                                                                                                                                                                                |                          |
| Neck motion: satisfac <input type="checkbox"/> y <input type="checkbox"/> triction                                                                                                                                                                                          |                          | ECG _____ CBC _____                                                                                                                                                                                                                       |                          |
| Short and muscular neck <input type="checkbox"/> es <input type="checkbox"/> No                                                                                                                                                                                             |                          | CXR _____ Chemistry _____                                                                                                                                                                                                                 |                          |
| Jaw motion: satisfacto <input type="checkbox"/> re <input type="checkbox"/> ction                                                                                                                                                                                           |                          | U/A _____ Others _____                                                                                                                                                                                                                    |                          |
| Teeth: loose _____ capped _____<br>Broken _____ missing _____                                                                                                                                                                                                               |                          | Malaria smear                                                                                                                                                                                                                             |                          |
| Mallampati/OPV 1 2 3 4                                                                                                                                                                                                                                                      |                          |                                                                                                                                                                                                                                           |                          |
| <b>SYSTEM ASSESSMENT</b>                                                                                                                                                                                                                                                    | Normal                   | <b>SYSTEM ASSESSMENT</b>                                                                                                                                                                                                                  | Normal                   |
| <b>Respiratory</b>                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <b>Hepato/Gastrointestinal</b>                                                                                                                                                                                                            | <input type="checkbox"/> |
| Asthma -wheezing _____ apnea _____<br>Bronchitis _____ recent _____<br>URI _____<br>Dyspnea _____ SOB _____<br>Orthopenia _____<br>tuberculosis _____<br>Tobacco use _____ breath _____<br>sounds _____<br>Packs/day _____ clear _____<br>How many years _____ others _____ |                          | Nausea/vomiting _____ Hepatitis _____<br>GI reflex _____ ulcers _____<br>Hepatosplenomegally _____ jaundice _____<br>Malnutrition _____ diarrhea _____<br>Alcohol use _____ frequency _____<br>Street drug use _____ Type/frequency _____ |                          |
| <b>Cardiovascular</b>                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <b>Neuromuscular</b>                                                                                                                                                                                                                      | <input type="checkbox"/> |
| Cyanosis _____ murmur _____<br>CHF _____ Hypertension _____<br>Arrhythmia _____ Exercise _____<br>tolerance _____ Edema _____                                                                                                                                               |                          | Headache _____ ICP _____<br>Paresthesia _____ Paralysis _____<br>Loss of consciousness _____ seizures _____<br>Muscle weakness _____ syncope _____                                                                                        |                          |
| <b>Renal/Endocrine</b>                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <b>Birth and Developmental Hx</b>                                                                                                                                                                                                         | <input type="checkbox"/> |
| Diabetes _____ Urine _____<br>retention _____<br>Renal failure _____ Dysuria _____<br>Thyroid disease _____ UTI _____<br>BMI _____                                                                                                                                          |                          | Preterm _____<br>Neonatal problems _____<br>Apnea _____<br>Hx STDs in family _____                                                                                                                                                        |                          |
| <b>Others</b>                                                                                                                                                                                                                                                               | <input type="checkbox"/> | <b>Immunization Hx</b>                                                                                                                                                                                                                    | <input type="checkbox"/> |
| Last menstrual period/pregnancy _____<br>Bleeding tendency _____ Recent steroids _____<br>Cancer chemotherapy _____ Immuno _____<br>suppression _____<br>Dehydration _____ Sick cell _____<br>anemia _____                                                                  |                          | TB _____<br>DPT _____<br>MMR _____<br>OPV _____                                                                                                                                                                                           |                          |

# MADDAWALABU UNIVERSITY GOBA REFERRAL HOSPITAL

Patient name \_\_\_\_\_ card No \_\_\_\_\_ Address \_\_\_\_\_  
Preanesthetic evaluation form Age \_\_\_\_\_ yrs sex: male  
female

|                                                              |                                     |  |  |
|--------------------------------------------------------------|-------------------------------------|--|--|
| HIV yes <input type="checkbox"/> no <input type="checkbox"/> | not stated <input type="checkbox"/> |  |  |
|--------------------------------------------------------------|-------------------------------------|--|--|

|                   |                                                          |
|-------------------|----------------------------------------------------------|
| <b>ASSESSMENT</b> | Fit for anesthesia                                       |
|                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Planned anesthesia: general \_\_\_\_\_ Regional \_\_\_\_\_ MAC \_\_\_\_\_

Premedication ordered ☐ Yes ☐ No \_\_\_\_\_ Any objection to receiving blood products? Yes \_\_\_\_\_ No \_\_\_\_\_

ANESTHESIA PROVIDER name and signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CONSENT FORM** /የሰምምነት ቅጽ እኔ አቶ/ወ/ሮ \_\_\_\_\_ ሀኪም ሳሳሰቡኝ መሰረት

የአንስቱኝ/ሰመመን መድሀኒት ወስጄ ----- ላይ የቀድሞ ጥገና ህክምና እንዲደረግልኝ መስማማቴን በፊርማዬ አረጋግጣለሁ፡፡

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ANESTHESIA DEPARTMENT