Pre-Anesthesia Assessment & Anesthesia Planning Sheet
Mackay Memorial Hospital

Name： ☐M ☐F
Chart # Age ：
Ward：

Personal History （Filled By Patient）

In order for the anesthesiologist to fully understand your health condition and history, please complete this checklist and provide detail information where specified

1. Do you have any cardiovascular disorders? **☐No ☐Yes→**（☐Hypertension ☐Ischemic heart disease ☐Heart failure ☐Arrhythmias ☐Angina ☐Chest tightness ☐Shortness of breath after climbing two flights of stairs ☐Congenital heart disease ; regular medication ☐Yes ☐No）
2. Do you have any endocrine disorders? **☐No ☐Yes→**（☐Diabetes Mellitus ☐Thyroid dysfunction ☐Others; regular medication ☐Yes ☐No）
3. Do you have any respiratory disorders? **☐No ☐Yes→**（☐Common cold ☐Asthma or chronic bronchitis ☐Pulmonary tuberculosis ☐Others）
4. Do you have any neurological disorders? **☐No ☐Yes→**（☐Stroke ☐Spinal injury ☐Brain tumor ☐Epilepsy ☐Cerebral palsy ☐Others）
5. Do you have any gastroenteral disorders? **☐No ☐Yes→**（☐Hepatitis or abnormal liver function test ☐Cirrhosis ☐Jaundice ☐Gastric/duodenal ulcers）
6. Do you have any renal disorders? **☐No ☐Yes→**（☐Uremia ☐Abnormal renal function ☐Hemodialysis）
7. Do you have any coagulation or hematological disorders? **☐No ☐Yes→**（☐Gum or subcutaneous bleeding ☐Anemia ☐Thrombocytopenia ☐Hemophilia ☐Antithrombotic medication ☐Others:_____）
8. Are you using any medication other than those specified above? **☐No ☐Yes→**（☐ herbal medicine ☐Sleeping pills ☐Regulated narcotics ☐Hormonal supplement ☐Weight loss pills ☐Others:_____）
9. Are you allergic to any drugs? **☐No ☐Yes →**（☐Antibiotics ☐Anti-inflammatory drugs and pain killers ☐Alcohol ☐Anesthetics ☐Others or unknown: _____）
10. Have you ever had an operation under anesthesia? (If no, jump to 12) **☐No ☐Yes→**（☐Local anesthesia ☐Regional anesthesia ☐General anesthesia）
11. Did you experience any discomfort after anesthesia? **☐No ☐Yes→**（☐Nausea/vomiting ☐Hoarseness ☐Adverse reaction ☐Others _____）
12. Have any of your family members suffered from severe adverse reaction to anesthetics? **☐No ☐Yes→**（What kind of reaction: _____）
13. Do you use any of the following substances? **☐No ☐Yes→**（☐Cigarettes___pack(s)/day ☐Alcohol___bottle(s)/day）
14. Do you get motion sickness easily? **☐No ☐Yes**
15. Do you have any loose teeth or dentures? **☐No ☐Yes**
16. Do you have ankylosing spondylitis or rheumatoid arthritis? **☐No ☐Yes**
17. Are you wearing contact lenses or metallic jewelries? **☐No ☐Yes**
18. Are your pregnant? **☐No ☐Yes**

Signature：
Date：
Relation to patient：☐Myself ☐Family ☐Friend

Examinations Results and Anesthesia Plans （Filled By Anesthesia Team）

CXR:：☐ Done ☐ Not Done _____
EKG： ☐ Done ☐ Not Done _____
CBC : ☐ Done ☐ Not Done _____
Infectious disease：☐ None ☐ Open TB ☐ HIV ☐ Hepatitis ☐ MRSA ☐STD
Note：

Airway：☐Normal ☐Limitation of mouth opening ☐Short neck ☐ Stiffness of neck ☐Receding mandible
Teeth：☐normal ☐Abnormal (loose or missing：location _____)
ASA Class 1 2 3 4 5 E
Anesthesia：GA SA EA IVG Block _____
Post-op：Ward ICU Outpatient PCA PCEA

Signature of Anesthesiologist：_____，Date: _____