Pre-operative Evaluation Tool

	YES	NO
Do you see a cardiologist or have a history of heart Issues? (i.e.- irregular rhythm, coronary artery disease, congestive heart failure, valve issues)	☐	☐
Do you see a pulmonologist or have a history of lung issues or shortness of breath on exertion? (i.e.- chronic obstructive pulmonary disease/COPD, asthma, smoker, vaping, use of inhalers, smoke marijuana)	☐	☐
BMI	Height: ________ Weight: ________ BMI: ________	
Oxygen Saturation upon arrival to Chair? Oxygen Saturation after one minute in chair?	____________% ____________%	
Blood Pressure after 5 minutes in chair?	Systolic ________	Diastolic _________
Family History or personal History of problems with anesthesia?	☐	☐
History of IV Drug Use or have you ever needed ultrasound guidance for difficult IV access?	☐	☐