NURSING ASSESSMENT - PRE OP

Patient Name:_____________________________

Time in:______  ID Verification:_______  Right Eye:_____ Left Eye:_____

Allergies/Reactions:_______________________________________________________
______________________________________________________________________

Latex Allergy:  Yes___No___          NPO since:_______________

Medications taken today:_________________________________________________

Fasting blood sugar (if diabetic) results:  _______ @ _______ by patient____center____

Females, 50 years of age or younger, must have a pregnancy test:  Pos___Neg___

Refused:_______ (if patient refuses, they must sign a waiver)

Blood Pressure:_____  Respirations:____  Pulse:____  Temperature:____  SaO2:______

Transportation present:  Yes____  No____  If no, how is patient getting home:_________

Any evidence of skin infection:  ____________________________________________

Contact lens: Yes___  No___     Hearing Aid:  Yes_____  No____

**Contact lenses must be removed. Hearing aids may be removed just prior to surgery and placed in a small manila envelope with the patient's name on it.

Consent forms are signed and dated within 90-days.  Yes___  No___

History and Physicals are with the chart: Yes___  No___

Discharge Instructions have been reviewed with the patient and/or family member:
Yes___  No___

**Eye drops administered/times:______________________________________________

Comments:__________________________________________________________________
_________________________________________________________________________