

**Aravind Eye Hospital - Free Section** M.R. No. : \_\_\_\_\_

**Anaesthesia Record**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

**Operative Planned**

Weight  kg

Surgeon : Dr.

Anaesthetist :

Pre Operative

Examination

H/O DM /HT /IHD /BA

Temp : PR :

H/O Allergy to drugs

BP:

H/O Previous anaesthesia

CVS RS

H/O Recent URI

Investigation

Drug History

HB

Anti Hypertensive

Urine Albumin

Antibiotic

Urine Sugar

Antidiabetic

X-Ray / ECG

Antiepileptic

Others

Others

Premedication

Operative

Time

PR : BP :

Atropine

Mask

ETT

Pyro

LMA

Midazolam

Pulse Oximeter

NIBP

## Drugs

Thio	<input type="checkbox"/>	Vec	<input type="checkbox"/>	O2	<input type="checkbox"/>
Propofol	<input type="checkbox"/>	Suxa	<input type="checkbox"/>	N2O	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	Atracuriam	<input type="checkbox"/>	Halo/Sevo	<input type="checkbox"/>
Pentazocine	<input type="checkbox"/>	Ondansetron	<input type="checkbox"/>	Fentanyl	<input type="checkbox"/>

## Incidents if any

Difficult intubation	<input type="checkbox"/>
Fall in O2 saturation <90	<input type="checkbox"/>
Rise in BP > 20%	<input type="checkbox"/>
Fall in heart rate > 20%	<input type="checkbox"/>
Hypotention	<input type="checkbox"/>
Extubation spasm	

## Post Operative

HR	<input type="checkbox"/>
RR	<input type="checkbox"/>
SPO2	<input type="checkbox"/>

## Time to Recover

Restlessness	<input type="checkbox"/>	Conscious	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>		