Introduction

The ultimate goals of preoperative and pre-procedure medical assessment of patients who are to undergo anesthesia care are to reduce the morbidity of surgery, to increase the quality but decrease the cost of perioperative care, and to return the patient to desirable functioning as quickly as possible. Traditionally, these goals have been facilitated by a preoperative meeting between the patient and the anesthesiologist. The meeting now has six specific purposes**(Michael, 2006):**

1. To obtain informations about the patient's medical history, physical and mental conditions, in order to determine which tests and consultations are needed.
2. Guided by patient choices and the risk factors uncovered by the medical history, to choose the care plans to be followed.
3. To obtain informed consent.
4. To educate the patient about anesthesia, perioperative care, and pain treatments in the hope of reducing anxiety and facilitating recovery.
5. To make perioperative care more efficient and less expensive.
6. To utilize the operative experience to motivate the patient to more optimal health and thereby improve perioperative and/or long-term outcome .

Preoperative evaluation strives to answer three questions: Is the patient in optimal health? Can, or should, the patient's physical or mental condition be improved before surgery? Does the patient have any health problems or use any medications that could unexpectedly influence perioperative events? More than 65% of all operations are performed on an outpatient basis, almost 10% in the surgeon's office, and another 20% to 30% as morning admissions. Unlike the old days, when the entire evening before surgery could be spent learning about the medically complex patient, anesthesiologists are now being asked to perform preoperative evaluation as they "run" from case to case.

It is very difficult to make an adequate preoperative evaluation in 5 to 15 minutes, and it is impossible to change any therapy or optimize any care that requires more than 10 minutes without increasing costs and inconveniencing all concerned. Furthermore, the pressure to proceed, even when there may be increased or unknown risk, is much greater when time is short than when such evaluations are done in advance. Frequently, old records are not available.**(Gibby and Schwab, 2008)** Also, the pressure to proceed quickly probably makes the consent process less informed and

the discussion of anxiety relief and preoperative pain therapy plans less thorough clearly. A change is needed if preoperative assessment is to be adequate, and more so if anesthesiology as a specialty is to continue to lead the movement fostering patient safety, optimizing perioperative outcome, and motivating a higher quality of life with fewer health care costs,also inadequate preoperative assessment is now one of the top three causes of lawsuits against anesthesiologists.

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