Health Survey

Dear Patient:

We at the Select Surgical Center welcome you to participate in your surgical care. We depend on this survey along with the information provided by your surgeon to provide you with the appropriate care. Please complete the comment section for any "yes" responses. Thank you for your help.

Name:_____ Date of Birth:_____ Height:_____Weight: _____
Two phone numbers where we can reach you: 1._____ 2. _____
Can we leave a message if we do not reach you? NO YES
May we speak to another person concerning your care? NO YES **and name of person**_____

List ALL medications (including strengths and doses) you are taking- include herbal and over-the-counter/weight loss meds

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List all previous surgeries and procedures requiring anesthesia:

_____ _____
_____ _____
_____ _____

List all drug and food allergies include reaction

_____ _____
_____ _____
_____ _____

	YES	NO	COMMENTS
Do you have a Latex Allergy (include reaction):	☐	☐	_____
Have you ever had a problem with anesthesia?	☐	☐	_____
Has anyone in your family had a problem with anesthesia?	☐	☐	_____
Do you have any problems with your back, neck or opening your mouth?	☐	☐	_____
Do you have high blood pressure?	☐	☐	_____
Do you have heart trouble?	☐	☐	_____
Do you have a heart murmur?	☐	☐	_____
Do you have chest pain?	☐	☐	_____
Have you had a heart attack?	☐	☐	_____
Do you have a pacemaker or defibrillator?	☐	☐	_____
Do you or have you EVER smoked? If YES- how much and how long?	☐	☐	_____
Have you had a cold or cough recently or currently?	☐	☐	_____

	YES	NO	COMMENTS
Do you or have you had asthma?	☐	☐	_____
Do you have emphysema or bronchitis?	☐	☐	_____
Can you walk up a flight of stairs without getting short of breath?	☐	☐	_____
Do you snore?	☐	☐	_____
Do you have sleep apnea?	☐	☐	_____
If yes do you use a CPAP machine	☐	☐	_____
Do you have diabetes?	☐	☐	_____
Do you have any thyroid disease?	☐	☐	_____
Do you have any kidney problems?	☐	☐	_____
Have you had hepatitis?	☐	☐	_____
Do you take a blood thinner?	☐	☐	_____
Do you, or anyone in your family, have a serious bleeding problem or diagnosed blood disorder?	☐	☐	_____
Do you have a seizure disorder?	☐	☐	_____
Have you had a stroke or mini-stroke?	☐	☐	_____
Do you have weakness of or paralysis of your arms or legs?	☐	☐	_____
Do you have psychiatric problems?	☐	☐	_____
Do you have any implanted devices?	☐	☐	_____
Could you be pregnant? Last menstrual period _____	☐	☐	_____
Do you drink alcohol, if yes, how much and how frequently?	☐	☐	_____
Do you use recreational drugs? List type and frequency	☐	☐	_____
Do you have any loose, capped or bonded teeth?	☐	☐	_____
Do you have dentures/removable dental work?	☐	☐	_____

Do you have anything specific you want to discuss with the anesthesiologist?

_____

_____

_____

Signature of person completing form:_____ Date_____

TO BE COMPLETED THE DAY OF SURGERY

I certify that I have had nothing to eat or drink since_____am/pm Date: _____

Patient Signature: _____ Date_____ Time _____

Name of Person who will driving me home _____ Phone # _____

Please print

Parent/Guardian of children 18 years of age and under must remain in the facility until patient is discharged.

Reviewed by: _____ Date_____ Time: _____