



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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have emphysema or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Can you walk up a flight of stairs without getting short of breath?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes do you use a CPAP machine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you, or anyone in your family, have a serious bleeding problem or diagnosed blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had a stroke or mini-stroke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have weakness of or paralysis of your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have psychiatric problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any implanted devices?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Could you be pregnant? Last menstrual period _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink alcohol, if yes, how much and how frequently?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use recreational drugs? List type and frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any loose, capped or bonded teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have dentures/removable dental work?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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: _____