



CROZER KEYSTONE SURGERY CENTER AT HAVERFORD

HEALTH SURVEY

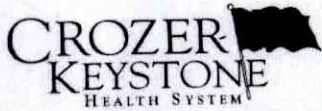
Patient Label

We welcome the opportunity to participate in your care. Patients requiring the services of the Department of Anesthesiology will be seen personally prior to surgery. This health survey allows us to identify patients who may need specialized instructions. We depend on this survey, along with the information provided by your surgeon, to develop a plan for your care.

Thank you for your help.

Name		Family Physician		
Age	Height	Weight	Home Phone	Daytime Phone

	YES	NO	COMMENT
• Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have angina or chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Have you had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Have you had a cold recently?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have a cough?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• 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 have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have a seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have a weakness of or paralysis of your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Have you had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Have you had hepatitis or jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you take a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• If yes, do you use a CPAP?	<input type="checkbox"/>	<input type="checkbox"/>	_____



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	YES	NO	COMMENT
• Do you have any psychiatric problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Have you had anesthesia previously?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Have you ever had a problem with anesthesia other than nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Has anyone in your family had a problem with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you smoke presently? If so, how much?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you drink alcohol? If so, how much?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have any loose, false, capped or bonded teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Do you have any problems with your neck or opening your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	_____

List all medications you are taking regularly on enclosed Medication Verification List. List medication name, dose, route (which means the way you can take it eg: by mouth) and frequency (how many times per day). The rest of the form will be completed by the nurse on admission.

List all previous surgery: _____

List all drug allergies: _____

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

Signature (patient, parent, legal guardian) Date Time

TO BE COMPLETED THE DAY OF SURGERY

I certify that I/the patient has had nothing to eat or drink since _____ a.m./p.m.

Signature (patient, parent, legal guardian) Date Time

I certify that the following individual will escort me/the patient home

Name Relationship Phone

Signature (patient, parent, legal guardian) Date Time