

HEALTH SURVEY

Dear Patient:

We at the Wills Surgery Center in Wilmington welcome the opportunity to participate in your surgical care. While all patients requiring the services of the Department of Anesthesiology will be seen personally prior to surgery, this Health Survey allows us to better identify those patients who may need specialized instructions. We depend on this survey along with the information provided by your surgeon to provide you with the appropriate care.

Thank you for your help.

Name				
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 any implanted device such as a cardiac defibrillator or pacemaker?	<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"/>	_____

(Other side please)

PATIENT LABEL

	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"/>	_____
• Do you take any of the following medications or herbal supplements for prostate, urinary or high blood pressure problems such as: Saw Palmetto, Flomax (tamsulosin), Uroxatrol (alfuzosin), Doxazosin, Hytrin (terazosin), prazosin or minipress? (please circle the supplement/medication)	<input type="checkbox"/>	<input type="checkbox"/>	_____

List all medications (including strengths and doses) you are taking regularly (including herbal remedies): _____

List all previous surgery: _____

List all drug allergies including reactions: _____

Latex Allergy _____

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

 Signature

 Date

TO BE COMPLETED THE DAY OF SURGERY

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

 Signature

 Date

I certify that the following individual will escort me home. Parent/Guardian of children 18 years and under must remain in the facility until patient is discharged.

 Signature

 Relationship

 Daytime Phone

 Signature

 Date