CROZER KEYSTONE HEALTH SYSTEM

CROZER KEYSTONE SURGERY CENTER AT HAVERFORD

Patient Label

HEALTH SURVEY

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?	☐	☐	
• Do you have heart trouble?	☐	☐	
• Do you have a heart murmur?	☐	☐	
• Do you have angina or chest pain?	☐	☐	
• Have you had a heart attack?	☐	☐	
• Have you had a cold recently?	☐	☐	
• Do you have a cough?	☐	☐	
• 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 have diabetes?	☐	☐	
• Do you have a seizure disorder?	☐	☐	
• Do you have a weakness of or paralysis of your arms or legs?	☐	☐	
• Have you had a stroke?	☐	☐	
• Have you had hepatitis or jaundice?	☐	☐	
• Do you take a blood thinner?	☐	☐	
• Do you have sleep apnea?	☐	☐	
If yes, do you use a CPAP?	☐	☐	

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

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