YOUR AMBULATORY SURGERY
CENTER IN WILMINGTON, DE

Health Survey

Dear Patient:

We at the American Surgery Center in Wilmington, DE 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	☐	☐	______
▪ 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 any implanted device such as a cardiac defibrillator or pacemaker?	☐	☐	______
▪ Do you snore?	☐	☐	______
▪ Do you have Sleep Apnea?	☐	☐	______
—— If yes, Do you use a CPAP machine?			

PATIENT LABEL

	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?	☐	☐	____________
▪ 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*)	☐	☐	____________ ____________

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 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