Dear Patient: We at the Grant Surgicenter welcome the opportunity to participate in your care. 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 physician to provide you with the appropriate care. THANK YOU for taking the time to complete this form. Please **mail** the **completed** survey to Grant Surgicenter in the envelope provided.

Name: _____Date your procedure is scheduled: _____

Age: _____ Height: _____ Weight: _____lbs. Physician: _____

Home Phone: _____ Cell phone: _____

Please list ALL MEDICATIONS and DOSAGES taken regularly:

_____
_____
_____

Please list ALL ALLERGIES to DRUGS, FOOD, etc. AND your REACTIONS:

_____
_____

Do you have any LATEX (balloons, gloves, etc.) allergies? (Please circle) Yes NO

Please list any previous surgeries/dates:_____
_____
_____

Question	Yes	No	Comments
Do you have high blood pressure?			
Do you have heart trouble or a heart murmur?			
Do you have a pacer defibrillator implant? If so, when was it inserted?			
Have you had a heart attack? If yes, when?			
Do you have angina or chest pain?			
Do you have *SLEEP APNEA?* Has it been diagnosed?			
Have you been to the emergency room or hospital in the last six months?			
Do you have *diabetes?*			
Do you have emphysema or bronchitis?			
Do you have asthma? If yes, last attack?			
Have you had a cold within the last month?			
Do you get short of breath walking up stairs?			
Do you have any problems with your thyroid?			
Do you have chronic kidney disease?			
Do you have or have you ever had a seizure			

PATIENT LABEL

disorder?			
Do you have weakness or paralysis of arm/leg?			
Have you had a stroke? If yes, when?			
Do you have a bleeding disorder or bruise easily?			
Do you have heartburn more than 1time weekly? Hiatal hernia?			
Have you ever had hepatitis or jaundice?			
Do you have any psychiatric problems?			
Could you be pregnant? Date of LMP			
Have you or anyone in your family ever had a problem with anesthesia other than nausea/vomiting?			
Have you ever smoked? How much? Have you quit? When?			
Do you drink alcohol? How much?			
Do you take any *over the counter medications, herbal, vitamins or recreational drugs?* If so, what?			
Do you have any hearing or visual problems?			
Have you ever been treated for a MRSA infection? If yes, When?			

Date: _____ Signature: _____