Bucks County GI Endoscopic Surgical Center
1339 Woodbourne Rd, Levittown, PA 19057-1504

Health Survey

Dear Patient,

We at Bucks County GI Endoscopic Surgical Center welcome the opportunity to participate in your care. While all patients requiring the services of the Department of Anesthesiology will be seen personally prior to a procedure, this Health Survey allows us to better identify those patients who may need specialized instructions. Please complete all sections of this Survey to the best of your ability. **Please bring completed Survey with you on the day of your procedure.** Thank You!

Name:_____ Date of Birth:_____Height:_____Weight:_____

Home Phone:_____ Daytime Phone:_____

Please check all that apply:

□ High blood pressure		□ Smoking History	_____Packs/day
□ Heart murmur	□ Pacemaker	□ Had a cold recently	□ Sleep apnea
□ Angina or chest pain	□ Defibrillator	□ Shortness of breath	□ CPAP machine
□ Heart attack	□ Heart bypass surgery	□ Asthma	□ Use an inhaler
□ Heart arrhythmia	□ Cardiac cath or stents	□ Emphysema, bronchitis	□ Use oxygen
Comments:		**Comments:**	
□ Blood disorder	□ Take blood thinners	□ Seizure disorder	□ Nerve problems
□ Cancer	□ Kidney problems	□ Stroke	□ Chronic pain
□ Diabetes	□ Take a water pill	□ Weakness in arms / legs	□ Physical limitation
□ Hepatitis or jaundice	□ Thyroid problems	□ Paralysis in arms / legs	□ Psychiatric problem
Comments:		**Comments:**	
□ Date of Last Menstrual Period: _____		□ Drink Alcohol □ Social □ Daily	
Could you be pregnant? □ Yes □ No		□ Use Recreational Drugs	
Comments:		**Comments:**	

Have loose, capped, bonded or false teeth □ Yes □ No
Problems opening mouth or moving neck □ Yes □ No
Have previously had anesthesia □ Yes □ No Any problems with anesthesia ? □ Yes □ No
Any family members that had problem with anesthesia? □ Yes □ No
□ Recent hospitalization or change in medical status
Comments:

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Who is your Primary Care Provider?_____Phone Number:_____

Do you have an Advance Directive? □ Yes □ No
If yes, did you bring a copy to place on your chart? □ Yes □ No

List all medications, vitamins, and/or herbal supplements that you take on a regular basis.

Drug Name	Dose	How Often	Drug Name	Dose	How Often

List allergies to medications, food, or latex. Please include type of reaction.

_____
_____
_____

List all previous surgery.

_____
_____
_____

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

_____
_____
_____

_____ _____
Patient Signature **Date**

TO BE COMPLETED THE DAY OF SURGERY

I have had nothing to eat or drink since _____a.m./p.m.

I will be transported home by_____.
Name **Relationship** **Phone**

_____ _____
Patient Signature **Date**