PRINCETON ENDOSCOPY CENTER
PRE-ADMISSION HEALTH SURVEY

Dear Patient:

We at Princeton Endoscopy Center, LLC, 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 the 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.

PLEASE NOTE- THE PERSON DRIVING YOU HOME WILL BE REQUIRED TO REMAIN IN THE CENTER WHILE YOU HAVE YOUR PROCEDURE, OR BE IMMEDIATELY AVAILABLE TO PICK YOU UP WHEN YOU ARE READY TO BE DISCHARGED.

Name					
Age	**Height**	**Weight**	**Home Phone**	**Daytime Phone**	**E-Mail Address**

	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 becoming 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 psychiatric problems such as Depression or anxiety disorder?	☐	☐	______
• Have you had cancer? If so what type?	☐	☐	______
• Have you had anesthesia previously?	☐	☐	______

(Other side please)

	YES	NO	COMMENT
• 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 presently smoke? 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?	☐	☐	____________________

Have you ever been told you have sleep apnea? [ ] [ ] Explain____________________

Have you ever been told you have TB? [ ] [ ] Explain____________________

List all previous surgery: ____________________

____

____

List all allergies (including medications, food, and other products& **their reactions**____________________

____

____

Who is your Primary Physician (name and address please) ____________________

____

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.

I certify that the following individual will escort me home and **will either remain in the Center or be immediately available to pick me up when I am ready to be discharged.**

____________________ Name

____________________ Relationship

____________________ Daytime Phone

____________________ Signature

____________________ Date