VAIL VALLEY SURGERY CENTER EDWARDS

ADMISSION HEALTH SURVEY SHORT FORM

Dear Patient: This Short Form Health Survey is designed to help us speed you through the admission process. Please circle / answer the following questions: Yes, No, ? = unsure/unknown. Please comment when indicated. It is important to provide accurate and complete information. Thank You.

Height ________________	Weight ________________	________ Comments
Have you ever had problems with anesthesia?	Yes No ?	________________
Has anyone related to you ever had a problem with anesthesia?	Yes No ?	________________
Do you have any lung or respiratory problems? Sleep Apnea?	Yes No ?	________________
Have you had a "cold" recently?	Yes No ?	________________
Have you had a chest xray in the past 6 months? Or EKG?	Yes No ?	________________
Do you have high blood pressure?	Yes No ?	________________
Do you have any heart conditions or problems?	Yes No ?	________________
Do you get chest pressure or pain with exertion or at rest?	Yes No ?	________________
Do you get winded walking up stairs?	Yes No ?	________________
Have you noticed an irregular heartbeat?	Yes No ?	________________
Do you have diabetes or high blood sugar?	Yes No ?	________________
Do you have kidney or bladder problems? Prostate?	Yes No ?	________________
Do you have any thyroid problems or take thyroid medications?	Yes No ?	________________
Do you have arthritis, joint problems, or connective tissue disease?	Yes No ?	________________
Have you ever had liver problems like hepatitis?	Yes No ?	________________
Do you have frequent indigestion, hiatal hernia, or ulcers?	Yes No ?	________________
Do you have anemia, sickle cell or have you had a blood transfusion?	Yes No ?	________________
Do you have bleeding problems or bruise easily?	Yes No ?	________________
Do you have back problems or other physical disabilities?	Yes No ?	________________
Do you have neurological problems? Seizures?	Yes No ?	________________
Could you be pregnant? Note date of last menstrual period if applicable.	Yes No ?	____________ LMP________
Do you wear contacts or glasses?	Yes No ?	________________
Do you have a hearing aid, or have any surgical implants?	Yes No ?	________________
Do you have loose or damaged teeth, caps, or dentures?	Yes No ?	________________
Do you ever use tobacco products?	Yes No ?	________________
Do you, or have you ever used alcohol?	Yes No ?	________________
Do you use any "recreational" drugs?	Yes No ?	________________
Are you "at risk" for HIV or any sexually transmitted disease?	Yes No ?	________________

Patient Label

Medications: List all medications including non-prescriptive and dietary supplements. Example: Herbs, Vitamins, Minerals, etc.

Name of drug:	Dosage:	Frequency:	Last taken:

Do you have allergies? ❑ Yes ❑ No

List all Drug, Food and Environmental Allergies and type of reactions:
Example: Morphine – Nausea

____

Previous Hospitalizations/Surgeries: List approximate dates and reasons. Note any complications or problems:

____

How long at altitude? ______________________ **What altitude do you live?** ______________________

Advance Directives / Medical Treatment Decision Information:

❑ **I do not have an Advance Directive, but Advance Directive information has been given to me.**

❑ **I have an Advance Directive and have provided a copy.**

❑ **I have an Advance Directive, but do not have a copy with me. The substance of my current Advance Directive includes:**

- ❑ Do Not Resuscitate
- ❑ Organ Donation
- ❑ Autopsy Requested
- ❑ Feeding Restrictions with exception of (types): ______________________
- ❑ Medication Restrictions with exception of (types): ______________________
- ❑ Other wishes/issues in my current Advance Directives includes: ______________________

❑ **I do not know what my current Advance Directive states.**

________________________________ ________________________________

Patient Signature (or Legal Representative) **Date** **Reviewed by /RN Signature** **Date**

Patient Label