PRE ANESTHESIA

HEALTH SURVEY QUESTIONNAIRE

Dear Patient:
Welcome! To provide you with a comfortable experience, there will be an anesthesiologist and nurse anesthetist involved in your care. Please answer the following questions, which will help us to provide you with the best care possible. **Please return as soon as possible to:**

Hamilton Endoscopy & Surgery Center
1235 Whitehorse-Mercerville Rd. Suite#310, Hamilton NJ 08619
Fax to: 609-581-6620

Procedure & Date: _____ **Dr. Afridi Baig Boucard Fayyaz**

Colonoscopy Endoscopy Flexible Sigmoid **Marulendra Zamir**

Hemorrhoid Banding Bravo

Print Name_____ **Male/Female Date of Birth**: _____

Phone: Cell: _____ **Home:** _____ **Work:** _____

Primary Care Physician: _____Date of last visit:_____

Food /Medication Allergies: _____ Latex Allergy : Yes / No

All Medications You Take:	***Dosage:***	***How often:***	***Reason/Diagnosis***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*(Additional space for medications and Vitamins/over the counter medications, on last page if needed)

Height: ft._____ **in.**____ **Weight:** _____ **Age:** _____ **BMI:**_____

Please check off all that apply

Please tell us your activity level

☐ **Very active:** (no restrictions)
☐ **Somewhat active:** (can climb 1 flight of stairs with no chest pain or shortness of breath)
☐ **Not active:** (chest pain or shortness of breath at 1 flight of stairs)

Sleep Disorder: Do you have a Diagnosis or Symptoms of **Sleep Apnea**? ☐Yes ☐No
If you answered YES, please answer the following questions, If NO, continue to next page.

Degree of Sleep Apnea: ☐ **MILD** ☐**MODERATE** ☐**SEVERE**
☐ Do you use a **CPAP and Mask?** **Neck Circumference**_____
How long have you had Sleep Apnea? _____ **How often do you use CPAP?** _____
☐ Do you snore while sleeping ☐ Do you feel excessively tired during the day
☐ Has anyone observed periods where you stop breathing while sleeping
☐ Do you have High Blood Pressure

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Please check off all that apply

Heart/Cardiac:

Name & Phone # of Cardiologist_____

☐ High Blood Pressure ☐AFib ☐Heart attack Date: _____

☐ **PACEMAKER:** ☐ **ICD-DEFIBRILLATOR**

Brand/Company:_____ **Date Implanted:**_____

*****Attach a copy of you Pacemaker/Defibrillator Card*****

☐ Chest Pain or Angina: Date of last episode: _____

☐ Heart murmur ☐CHF

☐ Palpitations or skipped beats ☐Pulmonary Hypertension

☐ Artificial Valve ☐ High Cholesterol

☐ **Heart surgery: When**_____ **Where:**_____ **Type:**_____

☐ **Cardiac Stents: How Many**_____

☐ **Anticoagulant/Blood Thinning Medication:** _____

Diagnostic tests:

☐ EKG: When _____ Where_____

☐ Stress Test: When_____ Where_____

☐ Cardiac Cath: When_____ Where_____

Bleeding tendencies or disorders

☐ Easily bruised ☐ Take blood-thinning medication

Respiratory/Pulmonary

Name & Phone # of Specialist:_____

☐ Current cold or sore throat

☐ COPD ☐ Emphysema ☐ Chronic Bronchitis ☐ Asthma

☐ Have you ever been hospitalized for asthma?

☐ Have you ever used steroids for asthma?

☐ Do you use oxygen at home?

☐ Do you have problems laying flat?

G.I/Gastrointestinal

☐ Constipation ☐ Diarrhea ☐ Rectal Bleeding ☐ Hemorrhoids ☐ Polyps

☐ Nausea ☐ Vomiting ☐ Ulcer ☐ Difficulty Swallowing

☐ Heartburn ☐ Anemia ☐ Abdominal Pain ☐ Hepatitis A B C

☐ Other GI Complaint:_____

☐ Routine Screening Test

☐ Personal History of Colon Cancer ☐Family History of Colon Cancer

Diabetes: Name & Phone# of Specialist: _____

☐ Diet controlled ☐Insulin Pump

☐ Oral medication

☐ Insulin Injections

☐ Do you monitor your blood sugar?

Thyroid/Endocrine/Renal

Name & Phone# of Specialist:_____

☐ **Hypo**Thyroid
☐ **Hyper**Thyroid : Please have MD. Fax most recent Thyroid Labs to 609-581-6620
☐ BPH (Enlarged Prostate) ☐ Kidney Stones
☐ Renal/Kidney Insufficiency ☐ Dialysis ☐ Other:_____

Neuro/Musculoskeletal

Name & Phone# of Specialist:_____

☐ **Seizure - Date of Last Seizure**_____ **Medication:**_____
☐ Stroke/CVA When:_____ ☐Any weakness since stroke? Side:_____
☐ TIA (transient Ischemic Attack)
☐ **Have you ever passed out?**
If yes, please explain_____
☐ Arthritis ☐TMJ ☐ MS ☐ ☐ Paralysis
☐ Neck/back Pain ☐ Vertigo ☐ Amputation: _____☐ Prosthesis_
☐ Headaches ☐ Dizziness ☐ Migraines: medication:_____
☐ Hip Replacement Side:_____ Date:_____
☐ Knee Replacement Side:_____ Date:_____
☐ **Do you have difficulty opening your mouth? If yes**, please explain _____
☐ **Do you have any neck problems? If yes**, please explain _____

MISC:

☐ **Psychiatric Diagnosis**: ☐ Anxiety ☐Depression ☐ Stress ☐Bi-polar
Medication/Treatment:_____

☐ **Cancer:** Type:_____ When:_____ Treatment/Surgery:_____
☐ **Alcohol:** How much:_____ ☐ **Smoke cigarettes:** How much:_____ How Long___
☐ **Drug Use:** Substance name:_____☐ IV Drug Use: Date last used:_____
☐ **HIV** ☐ Difficult Stick/Vein access
☐ **Do you wear dentures**?
☐ **Upper:** Full ☐ or partial ☐
☐ **Lower:** Full ☐ or partial ☐
☐ **Loose teeth** - Location: _____
Could you possibly be pregnant? ☐ Yes ☐ No
When was your last menstrual period? _____ (if applicable)

Surgical History: *Please list all previous Surgeries or Procedures.*

_____ _____
_____ _____
_____ _____
_____ _____

Have you (or a family member) ever had problems with anesthesia? ☐YES ☐NO

If yes, please explain: _____

Do you have any questions you wish to discuss with an anesthesiologist concerning your procedure? _____
_____

_____ _____
PATIENT'S SIGNATURE **Date**

ADDITIONAL SPACE FOR MEDICATIONS IF NEEDED

Medication:	Dosage:	How often: