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 gastroenterologist to provide you with the appropriate care. Thank you for your help.

PLEASE ALSO BE ADVISED THAT THE PERSON DRIVING YOU HOME WILL BE REQUIRED TO REMAIN IN THE CENTER WHILE YOU HAVE YOUR PROCEDURE, OR MUST BE IMMEDIATELY AVAILABLE TO PICK YOU UP WHEN YOU ARE READY TO BE DISCHARGED

Name		
Age	**Height**	**Weight**

- Do you have a Living Will/Health Directive?

[ ] YES [ ] NO_____

- Would you like information on how to start one?

[ ] YES [ ] NO_____

- Do you have any cardiac issues such as high blood pressure, chest pain, arrhythmias (ex. A-fib)?

[ ] YES [ ] NO_____

- Have you had a heart attack or cardiac stents placed? If so, please state when.

[ ] YES [ ] NO_____

- Have you had a stroke? If so, please state when.

[ ] YES [ ] NO_____

- Are you on any blood thinners?

[ ] YES [ ] NO_____

- Do you have any current cold, flu, or COVID symptoms?

[ ] YES [ ] NO_____

- Do you have asthma, emphysema, or any other respiratory illnesses?

[ ] YES [ ] NO_____

- Have you ever been told you have tuberculosis?

[ ] YES [ ] NO_____

- Do you have sleep apnea?

[ ] YES [ ] NO_____

- Will you become short of breath if you walk up a flight of stairs?

[ ] YES [ ] NO_____

- Do you have diabetes? If so, are you on insulin or oral medication?

[ ] YES [ ] NO_____

- Have you ever had hepatitis or jaundice?

[ ] YES [ ] NO_____

- Do you have kidney disease?

[ ] YES [ ] NO_____

- Have you ever had a seizure or been told you have a seizure disorder?

[ ] YES [ ] NO_____

- Do you have any psychiatric problems such as Depression or Anxiety?

[ ] YES [ ] NO_____

- Have you ever been diagnosed with Cancer? If so, what type?

[ ] YES [ ] NO_____

- Have you had anesthesia in the past?

[ ] YES [ ] NO_____

- Have you ever had a problem with anesthesia, other than nausea or vomiting?

[ ] YES [ ] NO_____

- Has anyone in your family had a problem with anesthesia?

[ ] YES [ ] NO_____

- Do you currently smoke or vape? If so, how much?

[ ] YES [ ] NO_____

- Do you drink alcohol? If so, how many drinks per week?

[ ] YES [ ] NO_____

- Do you have any caps, crowns, bridges, dentures, or partial plates?

[ ] YES [ ] NO_____

- Do you have any loose, chipped, bonded, or missing teeth?

[ ] YES [ ] NO_____

LIST ALL PREVIOUS SURGERIES

_____

_____

PLESE LIST ANY OTHER MEDICAL CONDITIONS THAT HAVE NOT ALREADY BEEN MENTIONED ABOVE

_____

_____

I certify that the last time I swallowed anything (including prep, medications, liquid) was at _____ am/pm.
I certify that the following individual will escort me home and will either remain at the Center or be <u>immediately</u> available to pick me up when I am ready to be discharged.

_____

Escort Name Relationship Phone#

_____ _____

Patient Signature Date