Liberty SURGICAL CENTER, LLC.

HEALTH SURVEY

Dear Patient: We at Liberty Surgical Center welcome the opportunity to participate in your surgical care. 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 and family physician, to provide you with the appropriate care. THANK YOU for taking the time to complete this form. Please mail the completed survey to Liberty Surgical Center in the envelope provided.

Name: _____Date your surgery is scheduled: _____
Age: _____ Height: _____ Weight: _____lbs. Surgeon: _____
Home Phone: _____ Cell phone: _____

HIPPA GUIDELINES:
May we leave a detailed message on patient's answering machine: YES or NO

Please list ALL MEDICATIONS taken regularly:

_____
_____
_____Please list
ALL ALLERGIES to DRUGS, FOOD, etc. AND your REACTIONS:
_____
_____
Do you have any LATEX (balloons, gloves, etc.) allergies? (Please circle) Yes NO
Please list any previous surgeries/dates:_____
_____
_____

Question	Yes	No	Comments
Do you have high blood pressure?			
Do you have heart trouble or a heart murmur?			
Do you have a pacer defibrillator implant? If so, when was it inserted?			
Have you had a heart attack? If yes, when?			
Do you have angina or chest pain?			
Do you have *SLEEP APNEA?* Has it been diagnosed?			
Have you been to the emergency room or hospital in the last six months?			
Do you have *diabetes?*			
Do you have emphysema or bronchitis?			
Do you have asthma? If yes, last attack?			
Have you had a cold within the last month?			
Do you get short of breath walking up stairs?			

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Do you have a new cough with mucus?			
Question	**Yes**	**No**	**Comments**
Do you have any problems with your thyroid?			
Do you have or have you ever had a seizure disorder?			
Do you have weakness or paralysis of arm/leg?			
Have you had a stroke? If yes, when?			
Do you have chronic kidney disease?			
Do you have a bleeding disorder or bruise easily?			
Do you have heartburn more than 1time weekly? Hiatal hernia?			
Have you ever had hepatitis or jaundice?			
Do you have any psychiatric problems?			
Could you be pregnant? Date of LMP			
Have you or anyone in your family ever had a problem with anesthesia other than nausea/vomiting?			
Have you ever smoked? How much? Have you quit? When?			
Do you drink alcohol? How much?			
Do you take any *over the counter medications, herbal, vitamins or recreational drugs?* If so, what?			
Are you currently undergoing any dental work for an abscess or other infection?			
Do you have any loose, false, capped, bonded or chipped teeth?			
Do you have any hearing or visual problems?			
Do you have radioactive seeds in your body for prostate cancer?			
Do you have a history of using FLOMAX medication?			
Have you ever been treated for a MRSA infection? If yes, When?			

Date: _____ Signature: _____