



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 ? _____

VAIL VALLEY SURGERY CENTER

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Patient Label



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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
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