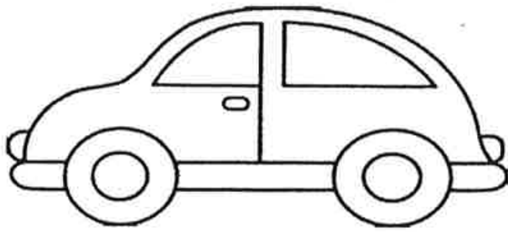
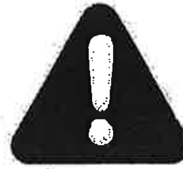


Ride is requested to stay on premises



ATTENTION: PLEASE READ YOUR PACKET AND FILL OUT THE ATTACHED INFORMATION THAT IS REQUIRED FOR YOUR APPOINTMENT

Welcome to the Princeton Endoscopy Center.

To expedite your admissions and make it go as smoothly as possible, we kindly ask that you use the following as a check off list prior to your appointment:

- **Fill out both pages of your Pre-Admission Health Survey and bring it with you. **(Please use pen for all forms)**
- **Fill out the Medication Reconciliation Form and bring it with you. ** (Attachments are not acceptable)**
- **Bring a photo ID**
- **Bring your insurance card(s)**
- **Bring a form of payment as it is *your responsibility* for any co-pays/co-insurance and/or deductibles owed the facility required by your health plan (For your convenience we accept American Express, Visa, MasterCard, Discover, Checks and Cash)**
- **Leave valuables at home such as jewelry and laptops, etc.**
- **Wear glasses instead of contact lenses**
- **Please refrain from wearing any perfume/cologne**

You will be receiving a phone call 24-48 hours prior to your procedure informing you of the exact time to report to the center. If for any reason you are unable to keep your appointment the day of your procedure, please contact us as soon as possible so that we may offer your time slot to another patient.

Thank you,

Princeton Endoscopy Center

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 surgeon 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 BE **IMMEDIATELY AVAILABLE** TO PICK YOU UP WHEN YOU ARE READY TO BE DISCHARGED.

PATIENT NAME:					
AGE:	**HEIGHT:**	**WEIGHT:**	**HOME PHONE:**	**CELL PHONE:**	**E-MAIL ADDRESS:**

	YES	NO	COMMENT
✦ Do you have a Living Will/Health Directive?	[ ]	[ ]	______________
Would you like paperwork on how to start one?	[ ]	[ ]	______________
✦ Do you have high blood pressure?	[ ]	[ ]	______________
✦ Do you have a heart murmur?	[ ]	[ ]	______________
✦ Do you have angina or chest pain?	[ ]	[ ]	______________
✦ Have you had a heart attack?	[ ]	[ ]	______________
✦ Have you had a cold recently?	[ ]	[ ]	______________
✦ Do you have a cough?	[ ]	[ ]	______________
✦ Have you had asthma?	[ ]	[ ]	______________
✦ Do you have emphysema or bronchitis?	[ ]	[ ]	______________
✦ Can you walk up a flight of stairs without becoming short of breath?	[ ]	[ ]	______________
✦ Do you have diabetes?	[ ]	[ ]	______________
✦ Do you have a seizure disorder?	[ ]	[ ]	______________
✦ Do you have a weakness of or paralysis of your arms or legs?	[ ]	[ ]	______________
✦ Have you had a stroke?	[ ]	[ ]	______________
✦ Have you had hepatitis or jaundice?	[ ]	[ ]	______________
✦ Do you take a blood thinner?	[ ]	[ ]	______________
✦ Do you have any psychiatric problems such as Depression or Anxiety Disorder?	[ ]	[ ]	______________
✦ Have you had cancer? If so, what type?	[ ]	[ ]	______________
✦ Have you had anesthesia previously?	[ ]	[ ]	______________

	YES	NO	COMMENT
✦ Have you ever had a problem with anesthesia other than nausea or vomiting?	[ ]	[ ]	______
✦ Has anyone in your family had a problem with anesthesia?	[ ]	[ ]	______
✦ Do you presently smoke? If so, how much?	[ ]	[ ]	______
✦ Do you drink alcohol? If so, how much?	[ ]	[ ]	______
✦ Do you have any loose, false, capped or bonded teeth?	[ ]	[ ]	______
✦ Do you have any problems with your neck or opening your mouth?	[ ]	[ ]	______
✦ Have you ever been told you have sleep apnea?	[ ]	[ ]	______
✦ Have you ever been told you have TB?	[ ]	[ ]	______

LIST ALL PREVIOUS SURGERIES:

____

____

LIST ALL ALLERGIES (INCLUDING MEDICATIONS, FOOD, OTHER PRODUCTS & THEIR REACTION)

____

____

WHO IS YOUR PRIMARY PHYSICIAN (NAME & ADDRESS PLEASE)

____

____

DO YOU HAVE ANYTHING SPECIFIC YOU WANT TO DISCUSS WITH THE ANESTHESIOLOGIST?

____

____

SIGNATURE **DATE**

____

TO BE COMPLETED THE DAY OF SURGERY

I certify that the last time I swallowed anything (including prep, medications, liquid) was at __________am/pm.

I also certify that the following individual will escort me home and will either remain in the Center or be immediately available to pick me up when I am ready to be discharged.

____

ESCORT'S NAME **RELATIONSHIP** **CELL PHONE#**

____

PATIENT'S SIGNATURE **DATE**