AtlantiCare SURGERY CENTER

2500 English Creek Avenue, Bldg. 700, Suite 702, Egg Harbor Township, NJ 08234
798 Route 539, Bldg. A, Suite 1, Little Egg Harbor, NJ 08087
106 Court House South Dennis Road, Bldg. 100, Cape May Court House, NJ 08210

**ADULT PATIENT HEALTH QUESTIONNAIRE**
**Please complete form immediately in its entirety.**
**Mail or Fax form to facility where your procedure is scheduled.**

Pre-Admission Nurse Telephone and Fax Numbers
Egg Harbor Township: 609-407-2211 / Fax: 609-645-2023
Ocean County: 609-296-1122 / Fax: 609-296-1142
Cape May Court House: 609-465-0300 / Fax: 609-465-8771

Name: _____ Telephone Preferred #1: _____

Telephone Preferred #2: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician: _____ Primary Care Physician: _____ Cardiologist: _____

Procedure: _____ Date of Procedure: _____

Age: _____ Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

**Allergies** (including medications, food and latex)**:**

_____

_____

**Previous operations (including implantable devices):**

_____

_____

_____

**Recent Hospitalizations / Treatments within last 12 months:**

| Date | Reason | Facility |
|---|---|---|
| | | |
| | | |
| | | |

**Do you have or have you ever had a history of:**

| | |
|---|---|
| **Y** □ **N** □ Problem with anesthesia - if yes please describe: | **Y** □ **N** □ Short of breath when you walk up a flight of stairs |
| | **Y** □ **N** □ Emphysema / COPD |
| **Y** □ **N** □ Has any family member ever had a serious, life-threatening problem with anesthesia? If yes please describe: | **Y** □ **N** □ Asthma – if yes please provide the date of your last episode |
| | **Y** □ **N** □ Do you use oxygen at home – if yes how often |
| **Y** □ **N** □ History of difficult intubation (breathing tube inserted) | **Y** □ **N** □ Diabetes |

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**Do you have or have you ever had a history of:**

| | |
|---|---|
| **Y** □ **N** □ Hiatal hernia | **Y** □ **N** □ Kidney disease **Y** □ **N** □ Dialysis |
| **Y** □ **N** □ Acid reflux | **Y** □ **N** □ Hypothyroidism **Y** □ **N** □ Hyperthyroidism |
| **Y** □ **N** □ Sleep apnea **Y** □ **N** □ If yes, are you on CPAP | **Y** □ **N** □ Back problems |
| **Y** □ **N** □ High Blood Pressure | **Y** □ **N** □ Neck problems |
| **Y** □ **N** □ High Cholesterol | **Y** □ **N** □ Arthritis |
| **Y** □ **N** □ Do you take blood thinners – if yes provide type and reason | **Y** □ **N** □ Bleeding disorder/or blood disease |
| **Y** □ **N** □ Do you have a history of Pulmonary Embolism (clots in lungs)<br>**Y** □ **N** □ Do you have a history of Deep Vein Thrombosis (clots in legs) | **Y** □ **N** □ Do you have a history of a resistant bacteria, such as MRSA? Or if hospitalized, did staff wear gowns and gloves each time they entered the room? |
| **Y** □ **N** □ Angina / chest pain | **Y** □ **N** □ Anemia |
| **Y** □ **N** □ Rapid or irregular heart beat | **Y** □ **N** □ Personal history of cancer - if yes please list type of cancer |
| **Y** □ **N** □ Heart murmur | **Y** □ **N** □ Family history of cancer - if yes please list type of cancer |
| **Y** □ **N** □ Heart failure | **Y** □ **N** □ Stroke / TIA – if yes provide the date and side effects |
| **Y** □ **N** □ Heart attack – if yes please provide the date | **Y** □ **N** □ Seizures – if yes provide the date of last seizure |
| **Y** □ **N** □ Valve disease – if yes please provide type | **Y** □ **N** □ Mental illness – if any please provide type |
| **Y** □ **N** □ Mitral valve prolapse | **Y** □ **N** □ Flu vaccine – if yes when |
| **Y** □ **N** □ Coronary Stent/Angioplasty – if yes please provide the number of stents and the date | **Y** □ **N** □ Do you drink alcohol – if so how much and how often |
| **Y** □ **N** □ Pacemaker<br>**Y** □ **N** □ Defibrillator | **Y** □ **N** □ Smoke - if yes how many packs per day and for how many years |
| **Y** □ **N** □ (EKG) Electrocardiogram – if yes please provide the date and where was it performed | **Y** □ **N** □ Do you use any recreational drugs – if yes please list |
| **Y** □ **N** □ Hepatitis or liver disease – if yes please provide date of diagnosis | **Y** □ **N** □ Female Patients: Could you be pregnant LMP |
| | **Special Needs:** |

**I** _____(patient name) verify that the information I provided in my health history questionnaire is a complete and accurate description of my medical/surgical history, including medication use. I understand that my treating providers need this information to plan my anesthesia and surgical care while in the Surgery Center and failure to accurately disclose this information could result in serious consequences to my health.

Signature:_____ Date: _____

**IF YOU RECEIVE ANY TYPE OF ANESTHESIA OR SEDATION, YOU MAY NOT OPERATE A MOTOR VEHICLE, AND WILL BE REQUIRED TO HAVE A RESPONSIBLE INDIVIDUAL ESCORT YOU HOME FOLLOWING YOUR PROCEDURE.**

**Anesthesia Review** _____ **Date** _____

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# Home Medication Reconciliation Form

| ALLERGIES: (including medications, food and latex)<br><br>□ No Known Allergies | **Information provided by:**<br><br>_____ |
|---|---|

Please list all medications including prescriptions (examples: pills, inhalers, creams, shots), over the counter medications (examples: aspirin, antacids, diet pills, herbals such as ginseng, gingko), vitamins and birth control medications. Include medications taken as needed (example: nitroglycerin, inhalers).

| Current Medication List<br>*(dosage, frequency and route)* | Last Dose Taken<br>*(date/time)* | Upon Discharge | |
|---|---|---|---|
| | | Yes | No |
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| New Prescription | Reason for Taking | Next Dose At<br>*(after discharge)* |
|---|---|---|
| | | |
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| | | |

**Nurse Signature:** _____ **Patient Signature:** _____

**Date** _____ **Time:** _____