GVH GRAND VIEW HEALTH

SURGICAL HEALTH ASSESSMENT

NAME: _____ DOB: _____ AGE: _____

Dear Patient:

We at Grand View Health 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 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. To help us, please answer the following questions as directed by your surgeon or his/her staff.

SECTION 1

Have you ever had a **heart attack**? ☐ Y ☐ N
Are you currently taking **blood thinners**? ☐ Y ☐ N
Do you see a **Cardiologist**? ☐ Y ☐ N
Have you had **cardiac surgery**? ☐ Y ☐ N
Are you a **diabetic**? ☐ Y ☐ N
☐ Type 1
☐ Type 2
Do you see a **Pulmonologist**? ☐ Y ☐ N
Have you ever had **Congestive Heart Failure**? ☐ Y ☐ N
Do you have **Chronic Obstructive Pulmonary Disease (COPD) ?** ☐ Y ☐ N
Have you had a **cardiac stent** placed in the last year? ☐ Y ☐ N
Do you have a **Pacemaker / AICD**? ☐ Y ☐ N
Have you been **hospitalized** in the last 60 days? ☐ Y ☐ N

SECTION 2

Do you have **shortness of breath** with activity? ☐ Y ☐ N
Do you have **chest pain** with activity? ☐ Y ☐ N
Has it been more than **one year** since you have seen your **family doctor**? ☐ Y ☐ N
Do you have a history of **high cholesterol**? ☐ Y ☐ N
Do you have an **insulin pump**? ☐ Y ☐ N
Are you being treated for **high blood pressure**? ☐ Y ☐ N
Have you ever had a **blood clot**? ☐ Y ☐ N
Do you have **renal failure**? ☐ Y ☐ N
Do you use **inhalers daily**? ☐ Y ☐ N
Do you receive **dialysis**? ☐ Y ☐ N

Date _____ Time _____ Patient Signature _____

****** FOR SURGEON AND OFFICE REVIEW ONLY******
REQUIRES SURGICAL RISK STRATIFICATION

Requires PCP Clearance if:

a. Patients answers **YES** to any question in **section 1**
b. Patient answers **YES** to **3 or more** in **section 2**

Surgeon to check clearance needed:

☐ None ☐ Cardiology ☐ Hematology/Oncology ☐ Pain Management
☐ PCP ☐ Endocrinology ☐ Nephrology ☐ Pulmonary

☐ Patient seen by PCP/Cardio: send Surgical Stratification Form

Date _____ Time _____ SURGEON SIGNATURE _____

Office staff to complete:

CLEARANCE APPT: DOCTOR: _____ DATE/TIME OF APPT: _____

CLEARANCE APPT: DOCTOR: _____ DATE/TIME OF APPT: _____