Please complete and send back your anesthesia health questionnaire at least 1 week prior to your procedure/surgery date.

Your history needs to be reviewed and verified with pre-procedure nurse prior to you receiving your arrival time for your procedure.

Please call 989-495-9100 if you have not completed history or received a phone call prior to your procedure date.

This information is important to you receiving safe and effective anesthesia for your procedure.

Thank you!

GREAT LAKES BAY Surgery & Endoscopy Center

4228 Bay City Rd
Midland, MI 48642

Patient Evaluation Form

Date of Surgery:

PATIENT: PLEASE COMPLETE THIS FORM IN BLACK INK AND RETURN BY MAIL OR UPON RECEIPT

Patient Name: _____ DOB: _____ Phone: _____

Procedure/Surgery: _____ Doctor: _____ Reason: _____

Primary Care Physician: _____ Last Physical Exam Date: _____

Cardiologist: _____ Specialists: _____

Height: _____ Weight: _____ BMI: _____

Sex Assigned at Birth (Male/Female/Intersex): _____ Gender Identity: _____

Allergies: ☐ Latex ☐ Tape ☐ Shellfish ☐ Eggs ☐ Peanuts ☐ No Known Allergies ☐ Other: _____
Reactions: _____

Any Communication Barriers your care team should be aware of? ☐ Yes ☐ No
Primary form of communication (language): _____

Any Cultural or Religious beliefs your care team should be aware of? ☐ Yes ☐ No
Please Explain if Yes: _____

Do you have an Advanced Directive?	☐ Yes ☐ No	If YES, GLB does not honor DNR's (Do Not Resuscitate) due to elective procedures.
Do you have a Power of Attorney?	☐ Yes ☐ No	If YES, please bring this with you on your date of service.
Legally, can you make your own medical decisions?	☐ Yes ☐ No	If NO & you are unable to make your own medical decisions, please have a guardian and paperwork present on your DOS

SUBSTANCE USE	YES	NO
Substance Abuse (if YES, please list: _____)	☐	☐
Alcohol use Number of drinks per week:	☐	☐
Marijuana use (Please hold for 24 hours)	☐	☐
Comments:		

NEUROLOGICAL	YES	NO
Dementia/Alzheimer's	☐	☐
Stroke/TIA/Mini Stroke	☐	☐
Seizures	☐	☐
Neuromuscular diseases	☐	☐
Anxiety/Depression	☐	☐
Fainting spells	☐	☐
Comments:		

LUNGS	YES	NO
Do you require supplemental oxygen at home?	☐	☐
Asthma, Cough, Cold, or Wheezing	☐	☐
Shortness of breath	☐	☐
COPD	☐	☐
Sleep Apnea? CPAP/BiPAP Machine	☐	☐
Smoker? Amt: _____ Years: _____	☐	☐
Blood Clots	☐	☐
Can you lay flat?	☐	☐
Comments:		

Continue to the next page to complete pre-admission.

GASTROINTESTINAL	YES	NO
GERD or Reflux	☐	☐
Cirrhosis	☐	☐
Comments:		

ENDOCRINE/METABOLIC	YES	NO
Kidney problems or Dialysis	☐	☐
Diabetes: Type:	☐	☐
Comments:		

CARDIAC	YES	NO
Heart Murmur	☐	☐
Congestive Heart Failure	☐	☐
Do you get short of breath or have chest pains when: climbing a flight of stairs, or doing light housework?	☐	☐
Heart Attack	☐	☐
Have you been hospitalized in the last 3 months for congestive heart failure, heart attack or angioplasty?	☐	☐
Chest pain or Angina in the last 12 months (related to your heart)	☐	☐
Heart surgery; bypass, or Valve replacement	☐	☐
Arrhythmias, Pacemaker, or AICD (Circle one)	☐	☐
Heart Cath., Stents, Stress Test (Circle one)	☐	☐
High blood pressure	☐	☐
Comments:		

Anesthesia	YES	NO
Difficult Intubation	☐	☐
Nausea or Vomiting	☐	☐
Family/personal History of Malignant Hyperthermia	☐	☐
Comments:		

ENT	YES	NO
Loose, Chipped, or Missing Teeth	☐	☐
Dentures or Partials	☐	☐
Problems Opening or Closing in your mouth	☐	☐
Difficulty moving your neck	☐	☐
Comments:		

MUSCULOSKELETAL	YES	NO
Muscle disease/Muscular Dystrophy	☐	☐
Assistive Devices (cane, walker, etc.)	☐	☐
Do you require a mechanical lift?	☐	☐
Comments:		

COMMUNICABLE DISEASES	YES	NO
Do you have any signs of infection? Fever, open wounds, recent flu or upper respiratory infection?	☐	☐
Are you being treated for any contagious diseases? HIV – Y / N	☐	☐
MRSA	☐	☐
Tuberculosis	☐	☐
Hepatitis - Type:	☐	☐
Insect Infestations?	☐	☐
COVID positive in the last 10 days?	☐	☐
Comments:		

OTHER	YES	NO
Bleeding, Anemia, Sickle Cell Disease (Circle One if YES)	☐	☐
Are you Pregnant? Last Period:	☐	☐
Steroid use in the last 24 hours?	☐	☐
Implanted Surgical Device? Comments:	☐	☐
Any History of Cancer?	☐	☐

Continue to the next page to complete pre-admission.

Current Medications (Please list below or attach a list to this form)				
Medication	**Dose**	**Times/Day**	**Reason for Medication**	**Last Dose (Office Use)**
Example: Vasotec	10 mg	2	Blood Pressure	

Past Surgeries & Procedures (Please list below or attach a list to this form)		
Procedure / Surgery Name	**Date**	**Notes**

☐ I have read and acknowledge that I understand the attached instructions for my upcoming procedure. (Please Check the Box)