

Endoscopy Health History/Physical

Name: _____ Date: _____

Completed by: Patient Family Member Nurse Physician Other

Reason for visit: _____ Family Physician(s): _____

Please list bowel preparation ordered: _____

<input type="checkbox"/> No Allergies		<input type="checkbox"/> Allergies			
Medication Allergies	What happens?	Medication Allergies	What happens?		What happens?
				Latex	<input type="checkbox"/> No <input type="checkbox"/> Yes
				Iodine	<input type="checkbox"/> No <input type="checkbox"/> Yes
				Food	<input type="checkbox"/> No <input type="checkbox"/> Yes

Medications: List ALL medications you are taking including insulin, over the counter, herbals, and vitamins
 NOT taking any medications

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency	Drug Name	Dose	Frequency

List medications that are prescribed but not taken:

HISTORY Check all that apply or have applied to you.

- No Yes **Neurological** Seizure Stroke TIA Do you take blood thinners? _____
- No Yes **Cardiovascular** High Blood Pressure Chest Pain/Tightness/Pressure/Heaviness Ankle Swelling Irregular heartbeat
 Murmur Congestive Heart Failure Angioplasty Heart Attack (when) _____ Internal Defibrillator
 Pacemaker _____ Valve Replacement _____ Heart Surgery _____ Please bring your card - Type _____
- No Yes **Pulmonary** Breathing Problems Short of Breath Productive Cough Smoker Packs per day _____
 Asthma Emphysema Sleep Apnea CPAP machine? - Yes No
- No Yes **TB Exposure** Do you have? Blood in Sputum Fever Night Sweats
 Have you ever been exposed to TB? Yes No Have you had a positive TB skin test? Yes No
 Have you ever taken medication for TB? Yes No
- No Yes **Gastrointestinal/Hepatic** Ulcer Reflux Hiatal Hernia Swallowing Difficulty Liver Disease Hepatitis
 Bleeding Disorder Clotting Problems Anemia _____
- No Yes **Endocrine / Immune** HIV/AIDS Diabetes Abnormally low blood sugar Thyroid Problems _____
- No Yes **Anesthesia / Surgical** Previous anesthesia problem - Describe: _____
 Family anesthesia problem Limitation of neck/jaw movement Loose/chipped teeth Dentures
- No Yes **Genitourinary** Kidney Disease Dialysis - Last Date: _____

List hospitalization, major surgeries and year: _____

<p>Are you currently being treated for any other conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes _____</p> <p>Pediatric Patients: Immunizations up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what is missing _____</p> <p>Comments: _____</p>	<p>FEMALES: If you have had a menstrual period in the last year, you will be asked to give a urine sample</p>
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DAY OF PROCEDURE INSTRUCTIONS

- Who will drive you home? _____ Who will stay with you at home? _____ PH #: _____
- Driver must stay with patient in the building during the surgery Bring drivers license / Insurance card
 - Leave valuables (inc. jewelry / piercings) at home Wear glasses Wear comfortable clothing

Patient / Guardian Signature: _____

PROVIDER'S PHYSICAL - Please DO NOT write below this line

Physical Exam:

Check box if normal: Neurologic Heart Lungs ASA STATUS: 1 2 3 4 5

Height _____ Weight _____ BP _____/_____ Pulse _____ Respirations _____ Temp _____ O₂ Sats _____

Other: _____

Anesthesia Plan: No Sedation Local IVMS

Impression: _____

Plan: _____

UPDATES:

Patient History and Physical information reviewed. Patient evaluated immediately prior to procedure and patient is deemed an appropriate candidate for scheduled procedure and anesthesia planned.

Physician Signature

Date