TELL US ABOUT YOURSELF

Please complete this form and bring it and this packet to your procedure.

Why are you having this procedure? _____

Do you take blood thinning medication? ❑ Yes ❑ No ***Are you, or could you be, pregnant?*** ❑ Yes ❑ No

Do you use oxygen at home? ❑ Yes ❑ No ***Amount of oxygen used*** _____

Do you smoke or use tobacco products? ❑ Yes ❑ No ***Amount/Frequency*** _____

Do you drink alcohol? ❑ Yes ❑ No ***Amount/Frequency*** _____

Do you use marijuana products? ❑ Yes ❑ No ***Amount/Frequency*** _____

Do you currently have any of the following medical conditions or history of? If yes, please briefly explain.

❑ Yes ❑ No Diabetes _____
❑ Yes ❑ No High Blood Pressure _____
❑ Yes ❑ No Heart Disease _____
❑ Yes ❑ No Asthma/COPD _____
❑ Yes ❑ No Stroke _____
❑ Yes ❑ No Liver Problems _____
❑ Yes ❑ No Blood Clots _____
❑ Yes ❑ No Kidney Problems _____
❑ Yes ❑ No Sleep Apnea _____
❑ Yes ❑ No Other _____

Previous Surgeries:

Surgery/Approximate Date: Surgery/Approximate Date:

_____ _____
_____ _____
_____ _____

Please list any of your blood relatives with a history of colon cancer or colon polyps (relation and age):

_____ _____

Previous Endoscopic Procedure Findings:

Colonoscopy_____ Approximate Date: _____

Upper Endoscopy _____ Approximate Date: _____

Do you have a living will? ❑ Yes ❑ No ***Do you have a medical durable power of attorney?*** ❑ Yes ❑ No

Do you want any information regarding these? ❑ Yes ❑ No

_____ _____

Signature ***Date***

Please complete medication form on back page.

PATIENT MEDICATION FORM

Allergies or Intolerances to Medications or Substances and Reaction: □ No Known Drug Allergies

_____

_____

_____

Home Medication on Admission (Prescriptions, OTC, Herbs, Vitamins, Supplements, Patches, Inhalers, etc.)				
Medication and Route (if other than by mouth)	Reason for taking med	Dose	Frequency	Last Taken

Verified medication list with patient pre-procedure : (RN initials) _____

New Medications / Previous medications with changes					
Medication / Reason	Dose	Route	Frequency	Indications/ Instructions	Last Dose

Above is a list of medications that you indicated you are currently taking. Unless otherwise noted, you should resume taking these medications. Please contact the physician who prescribed your medications if you have any questions. Medication prescribed as a result of your visit has been noted as well. Your signature below means you understand these instructions.

Medications given on date of procedure:

Pre-Procedure:
- □ No Medications
- □ Zofran for Nausea
- □ Other Medications: _____

After Procedure:
- □ No Medications
- □ Zofran for Nausea
- □ Other Medications: _____

During Procedure:
- □ No Medications
- □ Propofol for sedation
- □ Fentanyl for sedation or discomfort
- □ Versed for sedation
- □ Zofran for Nausea
- □ Other Medications: _____ _____

Patient/Responsible party signature: _____

Reviewed and copy sent with patient /Responsible party: Date: _____ RN Initials: _____