

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 Warfarin (Coumadin)? ☐ Yes ☐ No *Do you use oxygen at home?* ☐ Yes ☐ No

Are you, or could you be, pregnant? ☐ Yes ☐ No

Do you smoke or use tobacco products? Amount _____ *Do you drink alcohol?* Amount _____

Do you use marijuana products? ☐ Yes ☐ No

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

| | | |
|------------------------------|-----------------------------|---------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma/COPD _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Problems _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Clots _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sleep Apnea _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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:

Previous Endoscopic Procedures:

Colonoscopy _____

Approximate Date: _____

Upper Endoscopy _____

Approximate Date: _____

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

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

Signature

Date

Health History has been reviewed by _____ *RN* *Date* _____ *Time* _____



MEDICATION FORM

Name: _____ Date: _____

ALLERGIES: _____

At Skyline Endoscopy Center we understand that the safe management of your medications may be a challenge and we can provide assistance. In fact, it is something we take very seriously. We join with your physician in developing systems that assure that your next provider of care has full knowledge of your current medications. This allows safe administration of new drugs and avoiding duplication of drugs or dangerous drug interactions.

We call this “Reconciliation”...We think this is Important...and so should you!

You can help us by completing this form before you come to the Center. After your procedure is completed a copy of this form will be handed back to you with additional medications you received during your stay at the Center or that were prescribed for you on discharge.

PLEASE PRINT CLEARLY ANY MEDICATIONS YOU ARE TAKING—INCLUDING PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBALS

| DRUG NAME | STRENGTH | HOW MANY TIMES A DAY | TAKE FOR WHAT PURPOSE |
|-----------|----------|----------------------|-----------------------|
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NEW INSTRUCTIONS/PRESCRIPTION(S) ADDED TODAY UPON DISCHARGE:

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| | | | |
| | | | |

DURING YOUR VISIT YOU WERE GIVEN:

- ☐ PROPOFOL FOR SEDATION
- ☐ VERSED FOR SEDATION
- ☐ FENTANYL FOR DISCOMFORT
- ☐ CETACAINE SPRAY
- ☐ OTHER MEDICATIONS:

REVIEWED BY: _____

DATE: _____