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.

❑ 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:

_____ _____

Previous Endoscopic Procedures:

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***

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

Please complete medication form on back page.

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

NEW INSTRUCTIONS/PRESCRIPTION(S) ADDED TODAY UPON DISCHARGE:

DURING YOUR VISIT YOU WERE GIVEN:

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

_____

_____

REVIEWED BY: _____

DATE: _____