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

Please complete 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 a notation of any medications you received during your stay at the Center or that were prescribed for you on discharge.

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

_____

_____

Home Medication on Admission (Prescriptions, OTC, Vitamins, Supplements, Patches, Inhalers, etc.)				
Medication and Route (if other than by mouth)	Reason for taking medication	Dose	Frequency	Last Taken
Verified medication list with patient pre-procedure: (RN initials)				

Medications given on date of procedure:

Pre-procedure:

- ❑ No medications
- ❑ Medications given:

_____

_____

_____

During procedure:

- ❑ No medications
- ❑ Propofol for sedation
- ❑ Fentanyl for sedation
- ❑ Other medications:

_____

_____

After procedure:

- ❑ No medications
- ❑ Medications given:

_____

_____

_____

New Medications/Previous Medications with Changes				
Medication	Dose	Frequency	Last Taken	Indications/Instructions

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 you 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.

Patient/Responsible Party signature:

_____

Reviewed and copy sent with patient/responsible party:

Date: _____ RN Initials: _____