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 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

Please complete this form **before** you come to the Center. Include: Home Medications on Admission (Prescriptions, OTC, Herbs, Vitamins, Supplements, Patches, Inhalers, etc.) **PLEASE NOTE: WE DO NOT HAVE ACCESS TO OUTSIDE HEALTH RECORDS. YOU MUST FILL THIS OUT OR ATTACH A LIST.** 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 Medications on Admission (Prescriptions, OTC, Herbs, 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)_____				

STAFF USE ONLY. PLEASE DO NOT WRITE BELOW THIS LINE.

Medications given on date of procedure (to be completed by RN):

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	Route	Frequency	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 your medications if you have any questions. Medication prescribed as a result of your visit has been noted as well.

Reviewed and copy sent with patient/responsible party:

Date: _____ RN Initials: _____