CAROLINAS GASTROENTEROLOGY CENTERS

PATIENT INFORMATION - NAME: _____ D.O.B. __/__/____

Who is driving you home today? _____ **Phone number?** _____

An individual other than yourself is required to stay at the facility during the procedure. It is recommended that someone stays with you for the 24 hours following your procedure.

Is it OK for the doctor to **discuss the findings** with the person that is here with you? ❑YES ❑ NO

Why are you having a *colonoscopy*? ❑Bleeding ❑History of CA or polyps ❑No problems- 1st time screening

Why are you having an *EGD*? ❑Difficulty swallowing ❑Heartburn/Reflux ❑Barretts ❑Anemia ❑Black tarry stools

Current **Height**: _____ Current **Weight**: _____ (needed to give you the correct amount of medicine)

Date and Time you last drank ANY liquids: ____/____/____ _____

Date and Time you last ate solid food that you could chew (jello counts as liquid): ____/____/____ _____

Which prep did you take? ❑ NONE Check all that apply: ❑ Colyte ❑ Halflytely ❑ Nulytely ❑ Trilytely ❑ Enemas ❑ Magnesium Citrate ❑ Bisacodyl tabs (Dulcolax) ❑ MiraLAX ❑ Movi-Prep ❑ Suprep

Were you able to complete the colon cleansing prep?❑Yes ❑No ❑ N/A **If not, did you call the doctor?** ❑Yes ❑ No

Final Results of the prep: ❑ Liquid (colored water) ❑ Liquid with some stool ❑ Soft stool ❑ Solid stool

Please check the box for all that apply to you: ❑ **NONE OF THE BELOW APPLY TO ME**

❑ Current Cold / Upper Respiratory Infection ❑ Fever ❑ Reaction to Contrast Dye ❑ Hiatal Hernia

❑ History of Airway Difficulty ❑ Anesthesia Problems ❑ Other Sedation Problems

❑ Artificial Hips & or Knees (❑Right ❑Left) ❑ Heart Valve Replacement ❑ Pacemaker ❑ Defibrillator

❑ Removable teeth (partial plate, full denture, loose teeth, temporary crowns, etc.)

Enclosed in your packet, you will find the "Medicine Reconciliation Form". This has been provided to improve communication and medicine safety between you, your family and your healthcare providers. Please fill it out at home, to include dosages and when you took it last. Check your medication labels for spelling and doses. <u>Bring the completed form with you</u> to your Endoscopy procedure appointment. The Medication Form is a permanent part of your medical record.

Do you *usually* take any of the following? (Check all that you have ever taken)

❑ I **never take** ANY of the medicines below

❑ Aspirin ❑ Motrin, Advil, Ibuprofen ❑ Naprosyn, Aleve ❑ Other over the counter pain medicines
❑ Coumadin ❑ Plavix ❑ Heparin ❑ Lovenox ❑ Vitamin E ❑ Other blood thinning medication

Please **include** any of the above medications that you have taken in the last month, **when filling out the "Medicine Reconciliation Form".** List the dosages, how often you take them and when the last time you took them. Please include any herbal medications and other vitamins that you may also take.

Do you understand the uses of your medications and their possible interactions? ❑ YES ❑ NO

MEDICAL HISTORY for Carolinas Gastroenterology Centers

If "you" have ever had any of the following conditions, please check the box and put a short explanation:

If NONE, check here - ❑ **I have reviewed all** of the medical problems listed below and **NONE apply to me,** in the past or present**.**

❑Heart Problems _____

❑High Blood Pressure - Take meds for it? _____

❑High cholesterol – I take meds for it Am diet controlled

❑Kidney or Bladder disease_____

❑End Stage Renal Disease (Dialysis or transplant?)

❑Lung Problems _____

❑Sleep Apnea—Use? Oxygen CPAP BiPAP Ventilator

❑Liver Problems _____

❑ Vision or hearing: hearing aide? Contacts? Glasses?

❑Gastrointestinal Problems _____

❑Unexplained weight gain _____

❑ Have contagious illness or recent exposure _____

❑Cancer _____

❑Stroke & or Seizures _____

❑Anemia/Leukemia/Sickle Cell _____

❑Psychiatric Disorder _____

❑Depression or Anxiety _____

❑Blood Transfusion Reaction _____

❑Diabetic: Circle all you use: Insulin Oral med Diet

❑Glaucoma Right Eye Left Eye Both

❑Bleeding Disorder _____

❑Arthritis _____

❑Existing skin breakdown _____

❑Exposure to Chicken Pox within last 21 days?

❑ I could be Pregnant.

Last Menstrual Period ____/____/_____

❑ I am currently Breast feeding?

List which blood relatives have each of the illnesses listed and what form of the illness they have. ie Mom-Lung Cancer

❑Cancer _____

❑Heart Problem _____

❑Diabetes _____

❑Seizure &/or stroke_____

List all surgeries or procedures you have had, no matter how long ago. Include date if it occurred within the last 12 months.

_____

_____

_____

Have you ever used Tobacco? ❑ **Yes** ❑ **No**

Type: smoking or chewing Amt per day_____
How long? _____ Last occurrence: _____
Do you want to stop using tobacco? ❑Yes ❑No

Do you use alcohol? ❑Yes ❑No
Type: _____ Amount: _____
Frequency: _____Last occurrence: _____
Do you want to stop using alcohol? ❑Yes ❑No

Do you use recreational drugs: ❑Yes ❑No
Name: _____ Frequency: _____
Last occurrence: _____
Do you want to stop using drugs? ❑Yes ❑No

Have you ever been afraid of, hurt, or forced by anyone living in your home against your will? ❑Yes ❑No

Do you have **any learning needs** regarding today's procedure or about the care of yourself after you leave?

_____
_____

Have you experienced any of the following?
TB Signs and Symptoms:
❑Night sweats for more than 7 days
❑Cough for more than 2 weeks
❑Unexplained weight loss greater than 10 lbs.
❑History of TB, recent TB exposure or ⊕ PPD
❑Coughing up blood

Latex allergy risks:
❑Known Latex Allergy
❑Spina Bifida
❑A reaction to **handling** balloons, Band Aids, Poinsettias and/or rubber/elastic
❑A reaction to avocados, bananas, kiwi or chestnuts
❑Itching, tearing, sneezing or runny nose after a Dental procedure

***** IF YOU HAVE HAD PAIN IN THE LAST 12 HOURS*****
Please Complete the following

When did the pain start? _____
Where is the pain? _____
Is there a pattern to the pain?❑Constant❑Intermittent
❑Other: _____
On a scale of 1-10, how intense is the pain? _____
Worst pain: _____ Best pain: _____
How would you describe the pain?
_____
What activities or medications relieve the pain?
_____
What causes it to increase? _____
Does the pain affect your activities & quality of life? ❑Y❑N