SOUTHERN ILLINOIS ENDOSCOPY
PRE-PROCEDURE QUESTIONNAIRE AND HEALTH HISTORY

NAME_____**DOB**_____ **HEIGHT**_____ **WEIGHT**_____

WHY ARE YOU HERE TODAY? (Please circle all that apply)

SCREENING/CHECK-UP REFLUX ABDOMINAL PAIN BLOOD IN STOOL ANEMIA HISTORY OF ULCERS
HISTORY OF COLON CANCER HISTORY OF POLYPS BARRETT'S DIFFICULTY SWALLOWING DIARRHEA OTHER

PROCEDURE (S) ARE YOU HAVING TODAY (Please circle all that apply)
UPPER ENDOSCOPY (EGD) COLONOSCOPY FLEXIBLE SIGMOIDOSCOPY

PRIMARY CARE PHYSICIAN:_____

When was the last time you ate or drank anything? Date/Time_____

If given a bowel prep, did you complete it? ___N/A ___YES ___NO Results of bowel prep ___Clear ___Cloudy ___Poor

If Female, is there a possibility of being pregnant? ___YES ___NO ___N/A ___Hysterectomy ___ Tubal Ligation

When was your last menstrual period?_____

MEDICAL HISTORY: Have you ever had or have any of the following? Please check all that apply. Additional space below if needed.

	YES	NO		YES	NO		YES	NO
Heart disease (heart attacks, angina, irregular heart rate)			Vascular Issues, Blood Clots/DVT, or Pulmonary Embolism (PE)			Cancer/Malignancy		
High Blood pressure			Bleeding Disorder or Anemia			Anxiety or Depression		
Valve Replacement, Implanted Defibrillator/Pacemaker			Kidney Disease or Dialysis			Stroke and/or Seizures		
COPD, Asthma, Emphysema, or Shortness of Breath with Exertion			Hepatitis or Liver Disease			Any surgical metal in the body (pins, plates, screws, etc)?		
Obstructive Sleep Apnea/Use a CPAP			Diabetes			Do you smoke, have you been a smoker?		
Do you drink alcohol			Have you ever had complications from Anesthesia?			Do you have partials, dentures, or loose teeth?		
Do you wear contact lenses or glasses?			Joint Replacement			Do you use recreational drugs?		

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Please LIST YOUR ALLERGIES and REACTION. LIST ALL YOUR MEDICATIONS or attach a medication list (*It must contain the i nformation below*).

ALLERGIES: None (check the box if you do not have any allergies)

Source	Reaction	Source	Reaction
Example: Penicillin	*Hives*	3.	
1.		4.	
2.		5.	

Do you use Aspirin, Aspirin products, Blood Thinners or Anti-Inflammatory medications?

(Examples: ASA, Children's aspirin, Coumadin, Heparin, Plavix, Motrin or Ibuprofen) ___Yes ___No

Medication Name:_____**When did you last take this drug**?_____

It is very important that you provide complete and accurate information so that we can provide the best , safe care for you. Please let your nurse know if you cannot remember all of your medications.

MEDICATIONS: None (check the box if you do not take any medications, vitamins, herbals, etc)

DRUG & STRENGTH/ DOSAGE	FREQUENCY OR HOW OFTEN TAKING MEDICATION	LAST TIME/DATE MEDICATION TAKEN	DRUG & STRENGTH/ DOSAGE	FREQUENCY OR HOW OFTEN TAKING MEDICATION	LAST TIME/DATE MEDICATION TAKEN

For Office Use Only

SIGNATURES: DATE: **Name and DOB of patient verified by:_____**

1. Patient : _____
2. Guardian:(if patient not able to sign):_____
3. Pre-Op RN: _____
4. CRNA: _____

CRNA Comments: ASA Rating:_____ MP Class: