Endoscopy Health History Worksheet

Complete both sides of this form and bring it with you the day of your procedure. Please answer as many of these questions as you can. The nurse will review the questionnaire with you before your procedure.

CHECK ALL THAT APPLY

You are having a  Colonoscopy  Gastroscopy  Bronchoscopy  Paracentesis  Remicade Infusion  Capsule Endoscopy  Esophageal Manometry  Ph Study  Other ______________________

What symptoms are you having to require this procedure?__________________________________________________

Previous surgery/procedure:  Heart  Colon  Gallbladder  Stomach  Hysterectomy  Back  Knee  Laparoscopy  Colonoscopy  Gastroscopy  Bronchoscopy  Other ______________________  NONE

Previous Anesthesia:  General  Conscious Sedation  Epidural  Local  Spinal  NONE

Have you ever had a reaction to Anesthesia?  Yes  No  If yes, please describe____________________________________

Cardiovascular:  Chest Pain  Heart Attack  Mitral Valve Prolapse  Artificial Valve Replacement  Pacemaker  High Blood Pressure  Abnormal Heartbeat  Bleeding disorders  Other ______________________  NONE

Last seen by cardiologist:____________________

Respiratory:  Asthma  Emphysema  Pneumonia  Bronchitis  TB  Shortness of Breath  Sleep Apnea  Recent Cold  Other ______________________  NONE

TB screen:  Fatigue  Cough >2 weeks  Recent Change in Appetite  Loss of Wt.  Night Sweats  Bloody Sputum  NONE

Gastrointestinal:  Hepatitis  Liver Disease  Ulcers  Hiatal Hernia  Reflux  Nausea  Vomiting  Diarrhea  Constipation  Other ______________________  NONE

Renal:  Kidney stones  Failure  Incontinence  Urinary Frequency  Retention  Dialysis  Infection  Other ______________________  NONE

Miscellaneous:  Diabetes  Glaucoma  Arthritis  Seizure  Thyroid Disease  HIV/AIDS  Cancer  Headaches  Strokes  TIA  Anemia  Sickle cell trait  Recent Injuries  Mental Health Problems  Other ______________________  NONE

ALLERGIES:  ______________________  NONE

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Home Medication</th>
<th>Immunizations current?</th>
<th>LATEX SENSITIVITY:</th>
<th>Do you smoke?</th>
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<tbody>
<tr>
<td></td>
<td>Medication</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Dose</td>
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<td>Last Dose</td>
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<td>Do you drink alcoholic beverages?</td>
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<td>Never</td>
<td>Occasionally</td>
<td>Daily</td>
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<td>Do you use any illegal or recreational drugs?</td>
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<td>Yes</td>
<td>No</td>
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<td></td>
<td>Frequency</td>
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<td>Do you suspect you are pregnant?</td>
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<td>Yes</td>
<td>No</td>
<td>LMP: / / /</td>
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<td>Height</td>
<td>Weight</td>
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</tbody>
</table>

Are you taking any aspirin, arthritis medication or blood thinners?  Yes  No  Last dose ______________________
Implants:  ☐ Crowns  ☐ Caps  ☐ Bridges  ☐ Dentures  ☐ Lens  ☐ Pacemaker  ☐ Metal Parts  ☐ Joints
☐ Breast  ☐ Other ___________________________________________ ☐ NONE

Impairments:  ☐ Vision  ☐ Hearing  ☐ Speech  ☐ Ability to walk  ☐ Balance problems
☐ Other ___________________________________________ ☐ NONE

Check all that you have with you today:  ☐ Glasses  ☐ Hearing aid(s)  ☐ Cane  ☐ Wheelchair  ☐ Contacts
☒ Dentures  ☐ Bridges  ☐ Loose teeth  ☐ Prosthesis
☒ Other ___________________________________________ ☐ NONE

Have you been a patient at WakeMed Cary Hospital before?  ☐ Yes  ☐ No

Do you have a cultural/religious preference you would like us to note on your medical record?  ☐ Yes, ___________________________________________ ☐ No

Do you have Advanced Medical Directive, Living Will, Health Care Power of Attorney?  ☐ Yes  ☐ No
If yes, please bring a copy with you on the day of your procedure.
Would you like more information on Advance Directives?  ☐ Yes  ☐ No

Do you have any pain?  ☐ Yes  ☐ No  If yes please describe.__________________________________________
______________________________________________________________________________

You may experience some mild discomfort during your endoscopic procedure. What methods have you used in the past to help you with pain or discomfort?  Medication, Meditation, Relaxation, Repositioning, Music
☐ Other ___________________________________________

Our nursing staff will work to provide you with information regarding your procedure and plan of care, while you are in our facility. What methods of education work best for you?  Verbal explanation, Written instructions, Pictures
☐ Other ___________________________________________

Who is your primary care physician?______________________________________________________________

Who will be responsible for taking you home and caring for you 24 hours after your procedure?
________________________________________________________  Phone number______________________________

Your signature allows an Endoscopy nurse to contact you by telephone after your exam for post-procedure follow-up.
Phone________________________  Signature________________________

I am fully aware that I am not to operate any motor vehicle or make any important decisions until the day after my procedure, due to impairments caused by the sedating medications.

Patient / Guardian signature: ___________________________________________  Date: __________

RN reviewing worksheet signature: ___________________________________________  Date: __________

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