|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_ What procedure are you here for? | | |  | | |
|  | | | | | |
| Reason for having this procedure? | | |  | | |
|  | | | | | |
| Name & Phone number of person taking you home: | | |  | | |
|  | | | | | |
| ***Do you have Advance Directives, i.e., Living Will, etc., in place now? Y N*** | | | | | |  |  |  |  |
| If you have an Advance Directive, please provide CME with a copy for your chart. | | | | | |
| Height Weight Tobacco? Y N How much? | | | | | |
| Alcohol? Y N How much? Narcotics? Y N How much? | | | | | |
| Have you had any problems w/intravenous sedation? Y N Describe | | | | | |
|  | | | | | |
| **Females only-** Are you pregnant? Y N  We will call or email you 24-72 hrs after your procedure. Best # to call\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to leave a message? Y N | | | | | |
| **Please answer Yes or No to the following disorders and give any explanation necessary .** | | | | | |
|  | | | | | |
| **Disorder** | **Yes** | **No** | **Medications –include OTC and herbal medications** | **Dose** | **How often?** |
| High blood pressure |  |  |  |  |  |
| Heart problems (heart attack, CHF) |  |  |  |  |  |
| Heart surgery |  |  |  |  |  |
| Pacemaker/defibrillator |  |  |  |  |  |
| Lung problems (asthma,COPD) |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Sleep apnea Yes or NO CPAP Yes or No |  |  |  |  |  |
| Liver disease (hepatitis/jaundice) |  |  |  |  |  |
| Kidney problems |  |  |  |  |  |
| Family history colon cancer |  |  | **List surgeries/Explain any items if** | **needed** |  |
| Previous colonoscopy/polyps |  |  |  |  |  |
| Back/neck problems |  |  |  |  |  |
| Blood thinners/aspirin use |  |  |  |  |  |
| Seizures/stroke/mini stroke |  |  |  |  |  |
| Bleeding problems |  |  |  |  |  |
| Surgery (as an adult) |  |  | **ALLERGIES** |  |  |
|  |  |  | Reaction |  |  |
|  |  |  | This information is true and correct to the best of my belief. |  |  |
|  |  |  | Patient signature: |  |  |
|  |  |  | RN signature |  |  |
|  | | | | | |