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
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**

Home Medication

Medication	Dose	Last Dose

LATEX SENSITIVITY: ❑ Yes ❑ No
Immunizations current? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No Packs/day_____
Do you drink alcoholic beverages?
❑ Never ❑ Occasionally ❑ Daily
Do you use any illegal or recreational drugs?
❑ Yes ❑ No Type_____
Frequency_____
Do you suspect you are pregnant? ❑ Yes ❑ No
LMP: ____/ ____/____
Height _____ Weight _____

Are you taking any aspirin, arthritis medication or blood thinners? ❑ Yes ❑ No Last dose_____

Patient Label
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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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