PRE-ASSESSMENT RECORD

Patient Name: _____ Physician: _____

Procedure Date & Time: _____ Referring Physician: _____

MR#: _____ DOB: _____ Ht. _____ Wt: _____

Scheduled procedure: ☐ Colonoscopy ☐ EGD ☐ Dilation ☐ Flexible Sigmoidoscopy

Chief Complaint: _____

Check or circle for history of:

Cardiovascular ☐ Denies

☐ Artificial Valve ☐ Chest Pain ☐ HTN ☐ CHF ☐ Arrhythmias ☐ MI ☐ Coronary Artery Bypass

☐ MVP ☐ Pacemaker/ICD ☐ Endocarditis ☐ Cardiac Stents ☐ Other: _____

Respiratory ☐ Denies

☐ SOB ☐ Cough ☐ Asthma ☐ Emphysema ☐ COPD ☐ Pneumonia ☐ Bronchitis

☐ TB ☐ Sleep Apnea ☐ Uses CPAP ☐ Home O2 ☐ Smoking Amt._____ ☐ Other: _____

Neurological ☐ Denies

☐ Stroke ☐ Seizures ☐ Migraines/Headaches ☐ Dizzy/Balance Problems ☐ Other: _____

Musculoskeletal ☐ Denies

☐ Arthritis ☐ Back/Neck Problem ☐ Recent Falls ☐ Other: _____

☐ Aids to mobility: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Limb Prosthesis

Gastrointestinal ☐ Denies

☐ GERD ☐ Ulcers ☐ Barretts ☐ Hx Esoph CA ☐ Dysphagia ☐ Nausea ☐ Vomiting

☐ Weight Loss ☐ Anemia ☐ Epigastric pain ☐ Bloating ☐ Change in Bowel Habits ☐ Constipation ☐ Diarrhea ☐ Incontinence

☐ Crohns ☐ Ulcerative Colitis ☐ IBS ☐ Abdominal pain ☐ Diverticulosis ☐ Hemorrhoids ☐ Rectal Bleeding

☐ +Occult Blood ☐ Screening ☐ Hx of colon polyps ☐ Hx of Colon Cancer ☐ Personal ☐ Family Who/Age_____

☐ Other:_____

Misc.

Diabetes ☐ Yes ☐ No Controlled with: ☐ Diet ☐ Oral ☐ Insulin ☐ Hold am medication

Kidney: ☐ Yes ☐ No ☐ Stone ☐ Renal Failure ☐ Dialysis

Liver: ☐ Yes ☐ No ☐ Elevated enzymes ☐ Cirrhosis ☐ Varicies

Hepatitis: ☐ Yes ☐ No Type: _____

Bleeding Disorder: ☐ Yes ☐ No _____

Implants/Prosthesis: ☐ Yes ☐ No _____

Pregnant: ☐ Yes ☐ No ☐ N/A Mastectomy ☐ Yes ☐ No ☐ R ☐ L

ETOH Use: ☐ None ☐ Daily ☐ Social

Other: _____

Previous Surgeries:

_____

_____

_____

Communication

English Other: _____ Interpreter: ☐ Yes ☐ No

Hearing: ☐ Adequate ☐ HOH ☐ R ☐ L

Deaf ☐ R ☐ L

Hearing Aid(s) ☐ R ☐ L

Visual: ☐ Adequate ☐ Glaucoma ☐ Legally Blind

☐ Glasses ☐ Contacts ☐ Cataracts

☐ Lens Implants: ☐ R ☐ L

Dental: ☐ Dentures ☐ Partial(s) ☐ Upper ☐ Lower

☐ Loose Teeth: _____

Allergies: ☐ NKDA Latex ☐ Yes ☐ No Reaction_____

Medication	Reaction	Medication	Reaction

See Attached List

Current Medications: ☐ None ☐ Pharmacy_____

Medication		Medication	

See Attached List

Current Use of:

☐ ASA ☐ NSAID ☐ Anticoagulant: Stop Date:_____ Protime: ☐ Yes ☐ No

Pre-Procedure Antibiotics ☐ Yes ☐ No ☐ Medication: _____

Instructions Given: ☐ Diet ☐ Prep ☐ NPO After_____ Meds:_____

☐ Post OP Driver/16 Hr. Restriction ☐ Patient Rights & Responsibilites Given

☐ Informed of Advance Directive Advance Directive ☐ Yes ☐ No ☐ Here

☐ Advised on no out of town travel to a remote area or cruise ship for one week after polyp removal

Date/ Time of Interview:_____ Scheduler:_____

Nurse Review:_____ 10/17