Virginia Endoscopy Group, L.L.C. Pre-Endoscopy Assessment

#101 (Rev. 4/10)

PATIENT ID

2. Who is driving you home? (DRIVER MUST REMAIN HERE) 3. May we speak to him/her regarding the outcome of your procedure? Yes No 4. Way we speak to him/her regarding the outcome of your procedure? Yes No 5. Are you wearing dentures? Yes No 6. Are you wearing a hearing aid? Yes No 7. Do you have artificial joints or implants? Yes No 8. Do you have englasses/contact lenses with you? Yes No 9. Are you wearing a hearing aid? Yes No 9. Height Weight Weight Weight Weight Weight Weight Yes No 9. Height Weight Weight Weight Yes No 9. Height Yes No 9. Height Weight Yes No 9. Height Yes No 9. Height Weight Yes No 9. Height Yes No	Arriv	al Time:	_								
Please complete all questions and sign. Use blue or black ink.	Fam	ily Doctor:									
1. Why are you having this procedure? Describe your symptoms	Have	e you ever had a procedure performed at Virg	ginia Endos	сору? 🗖	Yes 🗆	l No					
3. May we speak to him/her regarding the outcome of your procedure? Yes No	Ι. Ρ 1.										
3. May we speak to him/her regarding the outcome of your procedure? Yes No	2	Who is driving you hama?							/DDIVED MIII	ST DEMA	IN HEDE\
PERSONAL/MEDICAL/SURGERY HISTORY Heart Munur/Heart Disease Yes No 6. Are you wearing dentures? Yes No No No No No No No N				Our proce	adura?	□ Vac			(DRIVER MIC	SI NEIVIA	IIN HERE)
Heart Mumur/Heart Disease				oui pioci	edule:	— 163	_ 100				
Mitral Valve Prolapse	4.			□ No	5	Are voi	wearing d	entures?		□ Yes	□ No
Pacemaker/Delibrillator						•	•				
Diabetes		·							?		
Stroke/Seizures Yes No 9. Height Weight Yes No No No No No No No N											
Liver Diseases									, with you.	- 100	
Previous Problems/Sedation/Analgesia Yes No 11. Pregnant NA Yes No No 12. Tobacco Use #Packs No No 12. Tobacco Use #Packs No No No No No No No N								9111		□ Yes	□ No
History-Sleep Apnea / CPAP						0			□ N/A		
Bowel Disease/Surgery Kidney Problems								#Packs			
Kidney Problems Yes No Recreational Drug Use Yes No Representatory Lung Problems Yes No Respiratory Lung Problems Yes No Cancer Glaucoma Yes No Yes No Yes No High Blood Pressure Yes No High Blood disorder (HIV, Anemia, Hepatitis) Yes No No No No No No No N					12.						
Respiratory Lung Problems									•		
Cancer Glaucoma High Blood Pressure Blood disorder (HIV, Anemia, Hepatitis)		Respiratory Lung Problems				ricorca	lional brug	030		- 103	_ 110
Glaucoma High Blood Pressure Blood disorder (HIV, Anemia, Hepatitis) Yes											
High Blood Pressure Blood disorder (HIV, Anemia, Hepatitis)					13.	YOU W	ILL RECEI	VE A SEDATIVE FO	R YOUR PRO	CEDURE	THE
Blood disorder (HIV, Anemia, Hepatitis)						FOLLO	WING RES	TRICTIONS REMAI	N IN EFFECT	FOR 12 H	IOURS:
14. V.E.G. IS NOT RESPONSIBLE FOR VALUABLES OR PERSONAL BELONGINGS. PLEASE LEAVE THEM WITH YOUR DRIVER. () Initials 15. List all operations you have had: 16. Do you need to take antibiotics before going to the dentist?		· ·								gn legal	
BELONGINGS. PLEASE LEAVE THEM WITH YOUR DRIVER. () Initials 15. List all operations you have had:		blood disorder (riiv, Ariemia, riepatitis)	□ 165			docum	ents or co	nsume alcohol. () Initials		
15. List all operations you have had: 16. Do you need to take antibiotics before going to the dentist? Yes No					14.						
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16. Do you need to take antibiotics before going to the dentist?	15	List all operations you have had:									
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Latex allergy/sensitivity: Yes No Drug allergies and reactions:	16	Do you need to take antibiotics before go	ing to the c	lentist?	П Уез	: D No)				
18. Drug allergies?			-	ioritiot.			•				
List all medications, including BLOOD THINNERS, i.e., Coumadin, Heparin, Plavix, aspirin, and all Over-the-Counter drugs taken on a daily basis: Medication		Drug allergies? D Yes D No. List drug a		l reaction	٥.						
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20. Did you take the laxative ordered?		basis.									
20. Did you take the laxative ordered?	Me	dication			Dos	age		Frequency	Last Do	se Taken	
Did you complete? 21. Last time you had solid foods date & time Date Completed By (Patient's Signature) Date Date	1110	diodion			500	ago		Troquency	Luoi B	Joo Tartori	
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Did you complete? 21. Last time you had solid foods date & time Date	20.	Did you take the laxative ordered? Yes	□ NO							iviiraia	ιx
21. Last time you had solid foods liquids date & time Completed By (Patient's Signature) Date Reviewed By (Nurse's Signature) Date		5 11	5 N	iviag	citrate	IVIC	oviprep	_ Osmoprep v	ISICOI		
Completed By (Patient's Signature) Date Reviewed By (Nurse's Signature) Date	0.4	•									
Completed By (Patient's Signature) Date Reviewed By (Nurse's Signature) Date	21.		liquids		Alian a	_					
Reviewed By (Nurse's Signature) Date		date & time		date &	time						
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	Revi	ewed By (Nurse's Signature)			_	Date					
Povioused By (MD Cignature)						-					
	Box	ewed By (MD Signature)				 Date					