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

PATIENT ID

Arrival Time: _____

Family Doctor: _____

Have you ever had a procedure performed at Virginia Endoscopy? ❑ Yes ❑ No

I. Please complete all questions and sign. Use blue or black ink.

1. Why are you having this procedure? Describe your symptoms _____
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. **PERSONAL/MEDICAL/SURGERY HISTORY**

Heart Mumur/Heart Disease	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No
Pacemaker/Defibrillator	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Stroke/Seizures	❑ Yes	❑ No
Liver Diseases	❑ Yes	❑ No
Previous Problems/Sedation/Analgesia	❑ Yes	❑ No
History–Sleep Apnea / CPAP ❑	❑ Yes	❑ No
Bowel Disease/Surgery	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No
Respiratory Lung Problems	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Blood disorder (HIV, Anemia, Hepatitis)	❑ 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 eyeglasses/contact lenses with you?		❑ Yes	❑ No
9. Height _____ Weight _____			
10. Living Will		❑ Yes	❑ No
11. Pregnant	❑ N/A	❑ Yes	❑ No
12. Tobacco Use #Packs_____		❑ Yes	❑ No
Alcohol Use Amount_____		❑ Yes	❑ No
Recreational Drug Use		❑ Yes	❑ No

13. **YOU WILL RECEIVE A SEDATIVE FOR YOUR PROCEDURE. THE FOLLOWING RESTRICTIONS REMAIN IN EFFECT FOR 12 HOURS: Do not Drive or operate equipment/machinery, sign legal documents or consume alcohol. ( ) Initials**
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? ❑ Yes ❑ No
17. Latex allergy/sensitivity: ❑ Yes ❑ No
18. Drug allergies? ❑ Yes ❑ No List drug allergies and reactions:_____
19. List all medications, including BLOOD THINNERS, i.e., Coumadin, Heparin, Plavix, aspirin, and all Over-the-Counter drugs taken on a daily basis:

Medication	Dosage	Frequency	Last Dose Taken

20. Did you take the laxative ordered? ❑ Yes ❑ No ____ Fleets ____ Colyte/Nulyte ____ Halflyte & Dulcolax Tabs ____ Miralax ____ Magcitrate ____ Moviprep ____ Osmoprep ____ Visicol
    Did you complete? ❑ Yes ❑ No
21. Last time you had solid foods _____ (date & time) liquids _____ (date & time)

Completed By (Patient's Signature) _____ Date _____

Reviewed By (Nurse's Signature) _____ Date _____

Reviewed By (MD Signature) _____ Date _____