Health Questionnaire/Nursing Assessment
Medication Reconciliation Form

Please list all medications you use: prescription, over the counter, or herbs

Medication Name	Dose	Route (pills, injection, cream, etc.)	Frequency	Last Dose

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Latex allergy? No ____ Yes ____, explain: _____

Patient Signature: _____

RN Signature: _____

Anesthesia Provider Signature: _____

FOR OFFICE USE ONLY

New Medication Name	Dose	Route (PO = Oral)	Frequency	Next Dose

Present Medication to discontinue

Special Instructions: _____

_____

_____

Medication Education Provided: ❑ Verbal ❑ Written

Physician Review: _____

For your safety, be sure to share a current list of all medications that you take with all of your healthcare providers.

Health Questionnaire/Nursing Assessment

Date: _____ / _____ / 20_____ PROCEDURE YOU ARE HAVING DONE: COLONOSCOPY EGD

INSTRUCTIONS: FILL OUT AND BRING THIS FORM WITH YOU THE DAY OF YOUR PROCEDURE.

Height: _____ Weight: _____

Do you have advanced directives (living will)? No ___ Yes ___,
If so, **bring a copy** with you the day of your procedure.
(For Nurse use only: Information offered? Yes ___ No ___ Accepted / Declined)
Have you or any family members ever had a problem with anesthesia? No ___ Yes ___, explain reaction:

_____

Have you ever been told by an anesthesia provider that you have a DIFFICULT AIRWAY? No ___ Yes ___
If you answered yes to this last question, please call CDEU to speak with an anesthesiologist at (302) 677-1617.
Do you have loose, chipped or capped teeth? No ___ Yes ___; DENTURES - UPPER _____ LOWER _____
Tongue piercing? No ___ Yes ___
Do you drink alcohol or have you in the past? No ___ Yes ___, how much a day? _____
Do you currently or have you in the past used tobacco products? No ___ Yes ___,how many years? _____,
how much a day?_____ when did you quit? _____
Do you currently or have you in the past used recreational drugs? No ___ Yes ___; what?_____
last use: _____

HEART CONDITIONS

Have you ever had a heart attack or have stents in your heart? No ___ Yes ___, how long ago? _____
Last Cardiac catheterization:_____ Last Stress Test:_____
Have you ever had an irregular heart beat? No ___ Yes ___, Atrial Fibrillation? No ___ Yes ___
Have you ever had high blood pressure? No ___ Yes ___
Do you have a pacemaker? No ___ Yes ___
Do you have an Automatic Implanted Cardiac Defibrillator (AICD)? No ___ Yes ___

LUNG CONDITIONS

Do you have a chronic cough? No ___ Yes ___
Do you have asthma, emphysema, or history of TB? No ___ Yes ___
Do you use inhalers or oxygen? No ___ Yes ___
Do you have Obstructive Sleep Apnea? No ___ Yes ___
Do you use a CPAP mask at night? No ___ Yes ___
Do you snore? No ___ Yes ___
Have you ever had lung cancer? No ___ Yes ___

KIDNEY CONDITIONS

Have you ever had any kidney problems? No ___ Yes ___; Were you ever on dialysis? No ___ Yes ___
Last treatment:_____

Health Questionnaire/Nursing Assessment

GASTROINTESTINAL PROBLEMS

Have you ever had jaundice or any other liver problems like Hepatitis? No ___ Yes ___

Have you had any significant weight loss in the last 6 months? No ___ Yes ___, how much? _____
planned or unexpected? _____

Have you ever had any of the following conditions? **(Please circle all that apply)**

Hiatal Hernia	Constipation	Family history of Colon Cancer
Heartburn	Blood in stool	
Chronic Diarrhea	Polyps on prior colonoscopies	

NEUROLOGICAL CONDITIONS

Have you ever had a stroke? No ___ Yes ___, Date: _____ Impairment after: _____

Have you ever had any of the following? **(Please circle all that apply)**

Epilepsy Seizures Fainting Passing out when blood is drawn

OTHER CONDITIONS

Do you have any limited mobility or difficulty turning? No ___ Yes ___, why? _____

Have you had any bleeding that does not stop within 2-3 minutes? No ___ Yes ___

Are you anemic (low red cell count)? No ___ Yes ___

Do you take Coumadin, Plavix or any blood thinner? No ___ Yes ___, time of last dose _____

Are you taking Aspirin or Anti-inflammatory medicines? No ___ Yes ___ last dose: _____
names of the medications: _____

Do you have Diabetes? No ___ Yes ___, on insulin? No ___ Yes ___, time of last dose: _____
Do you check your blood sugar regularly? No ___ Yes ___, last blood sugar:_____ time: _____

Do you have any thyroid problems? No ___ Yes ___

Are you claustrophobic? No ___ Yes ___

Have you been treated for any of the following? **(Circle all that apply)**

Depression Anxiety Nervousness

Could you be pregnant? N/A ___ Yes ___ No ___, last menstrual period ____/____/____.
Hysterectomy or Tubal ligation? No ___ Yes ___

Do you have a metal implant in your body, ie joint replacement? No ___ Yes ___, where? _____

Do you have a history of falling? No ___ Yes ___

Are you currently a victim of abuse? No ___ Yes ___

Is there anything else about your health history that we need to know? _____

_____

Patient's Signature _____ Date ___/___/_____ Time _____

Reviewing RN's Signature _____ Date ___/___/_____ Time _____

Anesthesia Provider _____ Date ___/___/_____ Time _____