CLINICAL ASSESSMENT AND PAST HISTORY

The information collected below is for confidential use by this facility only. Although this information may have been provided to your Physician at the office we do not have access to that information and appreciate your assistance in completing this.

Date: _____

Time: _____

Who is your Primary Care MD? _____

Is this your first visit here? ..... Y N

What is the reason for your procedure today?

_____

_____

Who will be taking you home today?

_____

Is this person waiting? Y N Contact# _____

Is this person your emergency contact?..... Y N

If no, please indicate your emergency contact:

Name: _____

Phone number: _____ Relationship: _____

***May the Doctor speak to your designated ride home today after your procedure as you may not remember? Y N**

Do you have any drug allergies? Y N (if yes please explain)

_____ _____

_____ _____

_____ _____

(Medications) (Reactions)

Please indicate Yes or No to the following questions. All yes answers will be discussed with the Nurse prior to procedure.

Heart Disease or Heart Problems.....	Y	N	Have you had any		
High/ Low Blood Pressure(Circle the one).....	Y	N	previous surgery.....Y	N	
Asthma/ Breathing Problems.....	Y	N	(If yes please indicate)		
Do you use Inhalers?.....	Y	N	_____		
Did you use them today?.....	Y	N	_____		
Do you have sleep apnea?.....	Y	N	_____		
Any kidney disease?.....	Y	N	_____		
Any Liver disease?.....	Y	N	_____		
Are you diabetic?.....	Y	N	_____		
Did you take your insulin today?.....	Y	N	_____		
Any family history of colon cancer?.....	Y	N	_____		
Any personal history of colon cancer?.....	Y	N	_____		
Do you have any bleeding problems?.....	Y	N			
Do you have any pain now?	Y	N	If yes where? _____		
Pain level (0 -10)	____		_____		
Do you have glaucoma/ eye disease?.....	Y	N			
Have you had a stroke or any other neurological problems?.....	Y	N			
Do you have seizures or epilepsy?.....	Y	N			
Do you have migraines/ severe headaches?.....	Y	N			
Do you have any back/neck/spine problems?.....	Y	N			
Any sudden unexplained weight loss/ persistent cough/ night sweats?.....	Y	N			
Do you have any immune diseases?.....	Y	N			
Any skin problems/sores/rashes?.....	Y	N			
Any possibility you are pregnant?.....	Y	N	(LMP- if applicable) _____		
Are you currently breastfeeding?.....	Y	N	**Do you have?**		
Are you currently the victim of abuse and want information about services available to you?.....	Y	N	Pacemaker/Implant? ...Y Do you have a card for this		N
Any anesthesia problems patient/family?.....	Y	N	device? ..... Y		N
Do you have an advanced directive?.....	Y	N	Dentures? ..... Y		N
Do you have any religious or cultural beliefs we need to be aware of today?.....	Y	N	Hearing Aides?.....Y Glasses? .....Y		N N

MEDICATION AND ALLERGIES

Latex Allergy Y N

Height: ___ft ____in Weight:_____ lbs

Please list all current medications:

None: _____

Medication	Dose (HowOften)	Last Taken

Do you use?

Vitamins Y N _____

Herbals Y N _____

Other(Explain) _____

_____

Do you take Aspirin on a regular basis? **Y N**

When did you last take? _____

Do you take anti-inflammatory meds? **Y N**

When did you last take? _____

Do you use tobacco? **Y N**

Do you drink alcohol? **Y N**

When did you last take? _____

Do you use recreational drugs? **Y N**

When did you last take? _____

Pt. Signature: _____

Patient Label Here

RN Verified Information: _____ Time: _____