2OPS

Procedure(s)________________________ Procedure Date __________
Doctor performing the procedure: ________________________ Primary Doctor________________________
Will you need an interpreter: NO YES If yes, what language? ________________________

You must have a ride home due to the medications you will receive. We will not discharge anyone alone by bus or cab!
(Except patients not receiving any sedation. i.e. patient having motility, or capsule endoscopy)

Name of person giving you a ride home: ________________________Phone #________________

Please answer questions and circle where applicable. Give details on *Yes* answers.	**Nurses comments**
1. Do you wear: glasses contact lenses hearing aid: left right dentures: upper lower partials **Height**_______ **Weight**_______	
2. Why are you having this procedure?	
3. Have you ever had this procedure before? NO YES	
4. What preparation, if any, did you take for this procedure? (Fleets phosphor-soda, Go-lytely, Half-lytely, Other__________________)	
5. Are you experiencing any pain at this time? NO YES Please circle your pain Level No pain Moderate pain Worst pain Location of pain:______________ 0 1 2 3 4 5 6 7 8 9 10 ☺ 😐 ☹	
6. Do you have any heart problems, chest pain, pacemaker or implanted defibrillator? If yes, explain: Defibrillator Type	
7. Do you have low or high blood pressure? NO YES	
8. Do you have any trouble breathing, asthma or lung problems? NO YES	
9. Circle any of the following if you have a history of: ulcers, hiatal hernia, swallowing problems, acid reflux, polyps, colitis, Crohn's, hemorrhoids, rectal bleeding, diverticulitis, abdominal pain or gall bladder problems.	
10. Do you have any history of hepatitis, jaundice or liver problems? NO YES	
11. Do you have any bleeding disorders? NO YES	
12. Do you have diabetes or blood sugar problems? NO YES	
13. Have you had any surgeries? NO YES Please list, including year:	
14. Do you have any artificial joints or implanted hardware? NO YES Please list,	
15. Do you have any history of neurological disease including fainting spells, convulsions, strokes or other? NO YES	
16. Do you any history of kidney or bladder problems? NO YES	
17. Do you have any current or recent infections? NO YES Where?	
18. Do you have a history of cancer? NO YES If yes, type and treatment?	
19. Do you have any skin problems: rash, sores, cuts, bruises? NO YES	
20. Is there a possibility you may be pregnant at this time? NO YES N/A	
21. Do you have any problems opening your mouth, or any jaw problems? NO YES	
22. Do you have any neck, back or other physical limitations/ problems? NO YES	
23. Do you or have you smoked? NO YES If yes, quantity and duration: __________ When did you quit? ______	

ADDRESSOGRAPH

Patient Name________________________

Cottage HEALTH SYSTEM

PATIENT QUESTIONNAIRE/ NURSING ASSESSMENT

ENDOSCOPY DEPARTMENT

Please fill out other side

Please answer all questions and circle answer where applicable. Give details on *Yes* answers.	**Nurses comments**
24. Do you drink alcohol? NO YES If yes, how much and how often?	
25. Do you use illicit drugs? NO YES If yes, what and how often?	
26. Do have any allergies to tape, iodine, latex, bananas or avocados? NO YES	
27. Have you taken Coumadin, Heparin or Plavix in the last 5 days? NO YES If YES, please circle drug, how much and what date did you last take it?	
28. Have you taken Aspirin or NSAIDS (i.e. Advil, Alka Seltzer, Ascriptin, Bufferin, Ecotrin, Motrin) in the last 5 days? NO YES If YES, please circle drug, how much did you take? What date did you last take it?	
29. Do you have any allergies to medications, or any unusual drug reactions? NO YES Please list:	
30. Please list any medications and/or supplements you take on a regular basis, **or** if you have a list of your medications, bring your list with you.	

Medication	**Dose**	**Frequency**	**Reason for taking this?**	**Did you take this AM?**	

Please list any other health problems you have:	

Date: ____________________ Patient signature: ______________________________________
Person filling out form if not patient: ______________________________ Relationship: ______________
Questionnaire reviewed with pt. and/or family by: ______________________ RN Date: ________ Time: ______

For Hospital Use Only						
Admission: Amb. / WC / Gurney / Other Pt. identified / stamp and name band correct ☐						
MD and procedure verified ☐ Consent signed ☐						
Procedure/ discharge teaching given/ pt.(or caregiver) acknowledges understanding/ questions answered: ☐						
Jewelry including any body piercing:						
Signs of abuse: Objective No Yes Subjective No Yes Comments :						
Mental/ Psychological/Social issues: No Yes Anxiety level: Calm Anxious Fearful						
Aldrete score	Respiration:	Circulation:	Color:	Consciousness:	Activity:	Total:
IV attempts___ Gauge____ Site ______ Fluid__________ Rate______ Time _____ by ______________________ RN						
Pre-procedure medications:#1 ________________ at_____ by_____ #2________________ at_____ by__________						
Comments:						

Nursing history and assessment completed by: ______________________ Date: __________ Time: _______

ADDRESSOGRAPH

Patient Name______________________

PATIENT QUESTIONNAIRE/ NURSING ASSESSMENT

ENDOSCOPY DEPARTMENT