

**HIGHLAND**  
HOSPITAL

**HIGHLAND ENDOSCOPY CENTER  
PREADMISSION  
HEALTH SURVEY**

**HH 10605APC MR**

Phone Number: 341-6877 • Fax Number: 341-8453

Outpatient

RR DONNELLEY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female Height \_\_\_\_\_ (in) Weight \_\_\_\_\_ (lbs)

Physician: \_\_\_\_\_ Procedure Date: \_\_\_\_\_

Type of Procedure: \_\_\_\_\_ Reason for procedure: \_\_\_\_\_

Who will be with you and driving you home from the hospital today? Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have any allergies to medications, foods, latex products:  Yes  No, If Yes please list:

Allergy/Reaction:	Allergy/Reaction:
_____	_____
_____	_____
_____	_____

**MEDICAL HISTORY: Please check (✓) if any conditions below have been a problem and circle the condition.**

- |                                         |                                         |                                                  |                                                 |                                        |                                       |                                               |                                                               |                                                                                       |                                                                  |
|-----------------------------------------|-----------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------|---------------------------------------|-----------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Flu                     | <input type="checkbox"/> COPD                   | <input type="checkbox"/> TB            | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Recent URI           | <input type="checkbox"/> SOB                                  | <input type="checkbox"/> Insomnia                                                     | <input type="checkbox"/> Sleep Apnea                             |
| <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> MI             | <input type="checkbox"/> Murmur or Valve disease | <input type="checkbox"/> CAD                    | <input type="checkbox"/> CABG          | <input type="checkbox"/> CHF          | <input type="checkbox"/> Irregular Heartbeat  | <input type="checkbox"/> Pacemaker                            | <input type="checkbox"/> ICD (↑)                                                      | <input type="checkbox"/> Cholesterol                             |
| <input type="checkbox"/> HTN            | <input type="checkbox"/> Stroke         | <input type="checkbox"/> TIA                     | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> GERD         | <input type="checkbox"/> Ulcer                | <input type="checkbox"/> Barretts Esophagus                   | <input type="checkbox"/> Varices                                                      | <input type="checkbox"/> Glaucoma                                |
| <input type="checkbox"/> IBS            | <input type="checkbox"/> Crohn's        | <input type="checkbox"/> Colitis                 | <input type="checkbox"/> hx polyps              | <input type="checkbox"/> Colostomy     | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Diabetes I,II                        | <input type="checkbox"/> Other _____                                                  | <input type="checkbox"/> Other _____                             |
| <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Pancreatitis   | <input type="checkbox"/> Gallbladder             | <input type="checkbox"/> Hepatitis _____ (type) | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Gout         | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Joint Disease                        | <input type="checkbox"/> Pregnancy: If No, _____ LMP                                  | <input type="checkbox"/> Alcohol use: (type and how often) _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Dialysis _____ | <input type="checkbox"/> Urinary Infection       | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Depression   | <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Tobacco use: (type and amount) _____ | <input type="checkbox"/> Recreational Drug use: (type and how often, last used) _____ |                                                                  |

**SURGICAL HISTORY:**  None

Year	Surgery	Year	Surgery

**Check all that apply**

- Full Dentures  Partial Dentures  Loose Teeth  Missing Teeth  Eyeglasses  Crutches  Wheelchair  
 Top  Bottom  Top  Bottom  Hearing Aid  Contact Lenses  Walker  Cane  
 Body Piercing All body piercing must be removed  Prosthesis

When was the last time you had liquids to drink? \_\_\_\_\_ When was the last time you had solid food? \_\_\_\_\_

**If the test you are having requires taking a bowel prep, please note medications taken.**

Ducolax Tablets # _____ amount	Golytely _____ amount
Miralax _____ amount	MOVI Prep _____ amount
Nulytely _____ amount	Magnesium Citrate _____ amount
Half Lytely _____ amount	Ismo Prep _____ tablets
Trilyte _____ amount	Did you finish all of the prep? <input type="checkbox"/> Yes <input type="checkbox"/> No

**DISCHARGE PLANNING SCREEN**

Do you live:  Alone  Family/Significant other Do you have help after discharge?  Yes  No

**Reviewed by RN:** \_\_\_\_\_ signature