

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"/> Seizures | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Dialysis _____ | <input type="checkbox"/> Urinary Infection | <input type="checkbox"/> Alcohol use: (type and how often) _____ | <input type="checkbox"/> Recreational Drug use: (type and how often, last used) _____ | <input type="checkbox"/> Tobacco use: (type and amount) _____ | <input type="checkbox"/> Pregnancy: If No, _____ LMP | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Walker | <input type="checkbox"/> Cane |

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