BRING THIS WITH YOU THE DAY OF YOUR PROCEDURE ALONG WITH A COPY OF THE HOME MEDICATION LIST

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.

☐ Bronchitis Pneumonia Flu COPD TB Asthma Recent URI SOB
☐ Chest Pain MI Murmur or Valve disease CAD CABG
☐ CHF Irregular Heartbeat Pacemaker ICD (↑) Cholesterol
☐ HTN Stroke TIA Anemia
☐ Hiatal Hernia GERD Ulcer Barretts Esophagus Varices
☐ IBS Crohn's Colitis hx polyps Colostomy Colon Cancer
☐ Thyroid Diabetes I,II Other ______
☐ Liver Disease Pancreatitis Gallbladder Hepatitis ______ (type)
☐ Kidney Disease Dialysis ______ Urinary Infection
☐ Arthritis Gout Osteoporosis Joint Disease
☐ Seizures Anxiety Depression Dementia/Alzheimer's

☐ Insomnia Sleep Apnea
☐ AIDS/HIV Autoimmune Disease
☐ Cancer ______
☐ Other ______
☐ Glaucoma Cataracts Lens Implant
☐ Pregnancy: If No, ______ LMP
☐ Alcohol use: (type and how often) ______
☐ Recreational Drug use: (type and how often, last used) ______
☐ Tobacco use: (type and amount) ______

SURGICAL HISTORY: ☐ None

Year	Surgery	Year	Surgery

Check all that apply

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

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
Miralax ______ amount
Nulytely ______ amount
Half Lytely ______ amount
Trilylte ______ amount
Golytely ______ amount
MOVI Prep ______ amount
Magnesium Citrate ______ amount
Ismo Prep ______ tablets
Did you finish all of the prep? ☐ Yes ☐ No

DISCHARGE PLANNING SCREEN

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

Reviewed by RN: ______ signature