St. Elizabeth's Medical Center
A STEWARD FAMILY HOSPITAL

GI Unit
Pre-Procedure Patient Questionnaire and Instructions

Please complete and bring with you to your appointment

PATIENT IDENTIFICATION

Patient Name:_____ Height:_____
Weight:_____

Person escorting you home: _____ Ride's Telephone #_____
Cell:_____

☐ Your escort will arrive in the GI unit no later than 4:30 pm ☐ Your escort will wait here

Please check the procedure you are having today: ☐ Colonoscopy ☐ Flexible Sigmoidoscopy
☐ Enteroscopy ☐ Upper Endoscopy/Egd ☐ ERCP ☐ Other

Reason for your procedure:_____

Please list all **allergies** and the reaction:_____ ☐ None

_____

What is your primary language?_____ Do you need an interpreter? ☐ Yes ☐ No

Your Personal History	Yes	No	Please explain if yes
Heart Disease/Heart attack/high chol	☐	☐	
Heart Murmur/Valve Replacement	☐	☐	
Angina/Chest pain	☐	☐	
High Blood Pressure	☐	☐	
Breathing/Lung problems	☐	☐	
Sleep apnea	☐	☐	Apnea machine settings
Seizures/Stroke/Epilepsy	☐	☐	
Liver/Kidney Disease	☐	☐	
History of Cancer	☐	☐	
Diabetes	☐	☐	Last blood sugar?
Thyroid problems	☐	☐	
Arthritis/Limitation of movement	☐	☐	
Implanted pacemaker/defibrillator	☐	☐	When?
Anemia	☐	☐	
Glaucoma	☐	☐	
Diarrhea/Constipation/Bloody stools	☐	☐	
Trouble swallowing/Food sticking	☐	☐	
Smoke? If yes, amount	☐	☐	If yes, 1-800-QUIT-NOW is available.
Recreational/illicit drug use	☐	☐	
Alcohol use	☐	☐	Amount:
Anxiety/Depression	☐	☐	
Peptic Ulcer disease/Reflux	☐	☐	

Other:_____

Have you or a family member had an adverse reaction to anesthesia or sedation? ☐ Yes ☐ No

If yes, please explain:_____

Have you or a family member had:

Colon cancer? ☐ Yes ☐ No
Stomach cancer? ☐ Yes ☐ No
Breast cancer? ☐ Yes ☐ No
Esophageal cancer? ☐ Yes ☐ No
Uterine cancer? ☐ Yes ☐ No
Polyps? ☐ Yes ☐ No

Are you pregnant or breast feeding? ☐ Yes ☐ No

If yes, please explain:_____

_____

PATIENT IDENTIFICATION

Your past surgical history (include if you have any metal pins/plates/screws/piercings):

Have you every been hospitalized for any other reason? ☐ No ☐ Yes, please explain:

PLEASE REVIEW THE INSTRUCTIONS YOU RECEIVED FROM YOUR DOCTOR'S OFFICE INCLUDING THE PREP. PLEASE COME TO THE GI UNIT ONE HOUR BEFORE YOUR APPOINTMENT.

NO IBUPROFEN, VITAMIN E, ANTI-INFLAMMATORY MEDICATIONS OR PRODUCTS CONTAINING THESE FOR 2 DAYS PRIOR TO YOUR PROCEDURE WITHOUT YOUR PHYSICIAN'S APPROVAL. YOU DO NOT NEED TO STOP ASPIRIN UNLESS INSTRUCTED BY YOUR DOCTOR. IF YOU ARE TAKING COUMADIN, PLAVIX, TICLID OR INSULIN, PLEASE CHECK WITH YOUR PHYSICIAN WHEN TO STOP TAKING THESE MEDICATIONS PRIOR TO YOUR PROCEDURE. DO YOU TAKE ANY OF THE ABOVE? IF YES, WHEN WAS LAST DOSE: _____ ☐ NO

YOUR PROCEDURE WILL NOT BE DONE UNLESS YOU HAVE A RIDE HOME WITH A RESPONSIBLE ADULT: THAT PERSON MUST COME TO THE GI UNIT TO ESCORT YOU OUT. A TAXI WITH A RESPONSIBLE ADULT *(NOT THE TAXI DRIVER)* IS ALLOWED.

Signature of person completing this form: _____ Date: _____

RN Validation: I have seen and assessed this patient and reviewed this pre-assessment form with the patient.

RN Signature _____ Date: _____ Time: _____