Colon & Rectal Specialists, Ltd.

PATIENT ID

PRE-PROCEDURE ASSESSMENT

Family Doctor: _____ Height: _____ Weight: _____

Please complete all questions and sign when completed.

1) Why are you having this procedure? _____

   Describe your symptoms: _____

2) Who is driving you home? _____ Is he/she here now? ❑ Yes ❑ No

   If not, driver's name and phone number: _____

3) Do you have an advanced medical directive? ❑ Yes ❑ No

MEDICAL/SURGERY HISTORY

Heart Murmur/Heart Disease..... ❑ Yes ❑ No
Valvular Heart Problem..... ❑ Yes ❑ No
Pacemaker/Defibrillator..... ❑ Yes ❑ No
Diabetes..... ❑ Yes ❑ No
Stroke/Seizure..... ❑ Yes ❑ No
Liver Diseases..... ❑ Yes ❑ No
Previous Problems Sedation/Analgesics..... ❑ Yes ❑ No
History Sleep Apnea..... ❑ Yes ❑ No
Bowel Disease/Surgery..... ❑ Yes ❑ No
Kidney Problems..... ❑ Yes ❑ No
Respiratory Lung Problems..... ❑ Yes ❑ No
Cancer..... ❑ Yes ❑ No

Glaucoma..... ❑ Yes ❑ No
Hypertension..... ❑ Yes ❑ No
Blood Disorder (HIV, Anemia, Hepatitis)..... ❑ Yes ❑ No
Are you wearing dentures?..... ❑ Yes ❑ No
Are you wearing a hearing aid?..... ❑ Yes ❑ No
Do you have artificial joints/implants?..... ❑ Yes ❑ No
Eyeglasses/contact lenses on/with you?..... ❑ Yes ❑ No
Pregnant?..... ❑ N/A ❑ Yes ❑ No
Tobacco Use.... ❑ Yes ❑ No If Yes, _____/day
Alcohol Use..... ❑ Yes ❑ No If Yes, _____/day
Recreational Drug Use ..... ❑ Yes ❑ No

1) Do you need to take antibiotics before going to the dentist? ❑ Yes ❑ No
2) List any operation(s) you have had: _____

_____

_____

_____

_____

_____

3) Latex allergy/sensitivity? ❑ Yes ❑ No
4) Did you use a bowel prep? ❑ Yes ❑ No **Which?** ❑ Fleets Prep ❑ Osmo ❑ Halflytely ❑ Movi ❑ _____
5) Last time you had solids? _____ Last time you had liquids? _____

Completed By Patient's Signature: _____ Date: _____

Reviewed By Nurse's Signature: _____ Date: _____ REV: 7/17

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PATIENT ID

PRE-ADMISSION MEDICATION LIST VERIFICATION & ORDER FORM (Medication Reconciliation)

Please list all of the patient's medications PRIOR TO ADMISSION, including OTC and Herbal Meds

Are you on blood thinners (Heparin, Coumadin, Aspirin, Ticlid, Persantine)? ❑ Yes ❑ No If Yes, date Stopped _____

ALLERGIES:

_____

_____

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

❑ **CONTINUE SAME MEDICATION SCHEDULE AS BEFORE**

Circle C to Continue or DC to discontinue upon discharge

CURRENT MEDICATION NAME (Write legibly)	DOSE (mg, mcg)	ROUTE (PO, GT, SC, IV)	FREQUENCY	LAST DOSE DATE/TIME	PHYSICIAN ORDER
1.					C DC
2.					C DC
3.					C DC
4.					C DC
5.					C DC
6.					C DC
7.					C DC
8.					C DC
9.					C DC
10.					C DC