Patient sticker

ENDOSCOPY SPECIALISTS

PATIENT MEDICAL HISTORY / ANESTHESIA / SEDATION EVALUATION FORM

COMPLETE FORM, SIGN AND BRING WITH YOU TO YOUR APPOINTMENT

For clinical use upon admission:	Current weight:__________lbs Blood pressure:_______/_______ Respirations: _______ Pulse: ________ SPO2: ______% Current height:________ BMI: _______ Neck circumference:_______cm Blood sugar (if applicable)_______ Temp: _________°F

PATIENT: CHECK ALL THAT APPLY TO YOU NOW OR IN THE PAST

CARDIOVASCULAR ☐ N/A
- ☐ Abnormal heart rhythm
- ☐ Artificial valve
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Angina/Chest Pain
- ☐ High Blood Pressure
- ☐ Pacemaker/ICD-bring card
- ☐ Myocardial Infarction/Heart attack
- ☐ Murmur/Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Stent / Angioplasty
- ☐ Valvular disease
- ☐ Other (Blood clots, etc.):

PULMONARY ☐ N/A
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD/Emphysema
- ☐ Pneumonia
- ☐ Productive cough
- ☐ Recent respiratory infection (last 2 weeks)
- ☐ Sleep apnea (bring CPAP)
- ☐ Shortness of breath/difficulty walking upstairs
- ☐ Tracheotomy
- ☐ Tuberculosis

Other (Blood clots, Allergies, etc.):

GASTROINTESTINAL ☐ N/A
- ☐ Abdominal/Epigastric Pain
- ☐ Barretts Esophagus
- ☐ Blood in stool
- ☐ Celiac Disease
- ☐ Difficulty chewing
- ☐ Cirrhosis
- ☐ Colostomy
- ☐ Constipation
- ☐ Crohns Disease
- ☐ Diarrhea
- ☐ Diverticulosis/Diverticulitis
- ☐ Esophageal stricture
- ☐ Esophageal varices
- ☐ Family history of colon cancer
- ☐ Family history of polyps
- ☐ Gallbladder problems
- ☐ Hemorrhoids
- ☐ Hepatitis A/B/C
- ☐ Hiatal hernia
- ☐ Irritable bowel syndrome
- ☐ Jaundice
- ☐ Nausea/Vomiting
- ☐ Personal history of colon cancer
- ☐ Personal history of colon polyps
- ☐ Personal history of esophageal cancer
- ☐ Personal history of gastric cancer
- ☐ Rectal bleeding
- ☐ Difficulty swallowing
- ☐ Ulcerative colitis
- ☐ Ulcers
- ☐ Unexplained weight loss
- ☐ Other:

Date of last colonoscopy:

ENDOCRINE / KIDNEY ☐ N/A

Diabetes, If yes, treatment:: ☐ Diet ☐ Insulin ☐ Oral medication
- ☐ Thyroid disease, type:
- ☐ Kidney failure / Renal Insufficiency
- ☐ Dialysis, circle rotation→ M W F or T T S
- ☐ Steroid use
- ☐ Other (Frequent Urinary Tract Infections, Enlarged Prostate, etc.):

NEUROLOGIC/MUSCULOSKELETAL ☐ N/A
- ☐ Accident/Injury
- ☐ Amputation
- ☐ Arthritis
- ☐ Headaches/Migraines
- ☐ Limited range of motion
- ☐ Multiple Sclerosis
- ☐ Neck / Back pain
- ☐ Paralysis
- ☐ Prosthesis
- ☐ Seizure disorder/Epilepsy
- ☐ Stroke, deficits:
- ☐ Transient Ischemic Attacks (TIA) / Cerebral Vascular Accident (CVA)
- ☐ Temporomandibular Joint Disorder (TMJ)
- ☐ Other (Anxiety, Depression, Cerebral Palsy, Mental Disorder, Polio, Muscle Weakness, Spinal Cord Abnormality, etc.):

MISCELLANEOUS ☐ N/A
- ☐ Anemia
- ☐ Auto-immune disorder (Rheumatoid Arthritis, Lupus, etc.), type:
- ☐ Bleeding disorders
- ☐ Cancer, type:
- ☐ Chemotherapy
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ HIV/AIDS
- ☐ Malignant Hyperthermia
- ☐ Sexually transmitted disease(s)
- ☐ Sickle Cell
- ☐ Loose/missing/capped teeth
- ☐ Bridges / Dentures / Partials
- ☐ Contact lenses
- ☐ Hearing aid(s)
- ☐ Other:

IF YOU HAVE NOT BEEN DIAGNOSED WITH SLEEP APNEA, COMPLETE THE BELOW SCREENING TOOL

- **Yes No** -Do you snore loudly?
- **Yes No** -Do you often feel tired, fatigued or sleepy during the day?
- **Yes No** -Has anyone observed you stop breathing during your sleep?
- **Yes No** -Do you have or are you being treated for high blood pressure?
- **Yes No** -Is BMI ______>35? (Nurse will measure)
- **Yes No** -Are you over 50 years of age or older?
- **Yes No** -Is neck circumference _______>40cm? (Nurse will measure)
- **Yes No** -Are you male?

"Yes" to **0-2** questions indicates Low Risk; **3-4** questions indicates Intermediate Risk; **>4** questions indicates High Risk

Clinical Use: Patient score: ☐ Low Risk ☐ Intermediate Risk ☐ High Risk

SOCIAL ☐ N/A
- ☐ Alcoholic beverages – Type: Frequency: Quit date:
- ☐ Recreational drugs – Type: Frequency: Quit date:
- ☐ Tobacco – Type (circle answer): Cigarettes and / or Smokeless tobacco
  Frequency (i.e. packs per day, etc.):
- ☐ Regular exercise program

WOMEN ONLY ☐ N/A

☐ Currently pregnant ☐ Hysterectomy ☐ Tubal ligation ☐ Menopause

Date of last menstrual cycle: **Yes No** – Still menstruating

ANESTHESIA HISTORY ☐ N/A

Date of last anesthesia:
- ☐ Nausea / Vomiting
- ☐ Abnormal reactions – Type:
- ☐ Relatives with abnormal reactions to anesthetics

ALLERGIES (List food and medication allergies below - more space on back)

Allergies:	Type of reaction:

MEDICATIONS: (List below (more space on back), including vitamins and herbal supplements)

Name of medication	Strength (mg, mcg, etc.)	How often taken	Date last taken

PAST SURGICAL PROCEDURES/HOSPITALIZATIONS
(More space on back – include psychiatric treatment)

PATIENT RELEASE FOR OBSERVATION OF PROCEDURE(S):

At times, ADC Endoscopy Specialists has visitors in the facility for purposes of observation and it is our policy to obtain your consent for observation of your procedure(s). Please either consent or decline below:

I hereby authorize and consent to the presence of observer(s) during my admission, procedure(s) and recovery period. I also authorize the observers to review my protected health information. Observers may include students, visiting nurses and/or medical doctors, representatives of the Center for Medicare & Medicaid Services (CMS), the Texas Department of State Health Services (TDSHS) and/or other accrediting agencies such as the Accreditation Association of Ambulatory Health Care (AAAHC). I understand that they have no role or responsibility in my care or in performing the procedure(s). I consent to the observation provided my identity is not revealed by the observer or by the descriptive texts accompanying them including all forms of protected information unless specifically released by me.

☐ **YES, I consent to the presence of observer(s)**

☐ **NO, I do not consent to the presence of observer(s)** **Patient/Guardian Signature:**_______________________________

Name, relationship and phone number for the person driving you home:

Date:_______________________________

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PATIENT MEDICAL HISTORY / ANESTHESIA / SEDATION EVALUATION FORM

ADDITIONAL PAST SURGICAL PROCEDURES AND HOSPITALIZATIONS:

ADDITIONAL ALLERGIES:

Allergies:	Type of reaction:

ADDITIONAL MEDICATIONS:

Name of medication	Strength (mg, mcg, etc.)	How often taken	Date last taken

EVERYTHING BELOW IS FOR CLINICAL USE ONLY - USE BY ANESTHESIOLOGIST/PHYSICIAN/LICENSED INDEPENDENT PRACTITIONER/CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) FOR ANESTHESIA/SEDATION PATIENTS:

☐ Medical history reviewed ☐ Airway shows no obvious obstruction ☐ Risks – See comments below

Pre-procedure Assessment Risks:____

____

____

____

ASA CLASSIFICATION OF PATIENT

- ☐ 1 – No organic, physiologic, biochemical or psychiatric disturbance. (Normal, healthy patient)
- ☐ 2 – Mid-moderate systemic disease; may or may not be related to reason for surgery. (Ex: hypertension, diabetes mellitus)
- ☐ 3 – Severe systemic disease. (Ex: heart disease, poorly controlled hypertension)
- ☐ 4 – Life threatening systemic disease. (Ex: congestive heart failure, persistent angina pectoris)
- ☐ 5 – Moribund patient. Little chance for survival. Surgery is last resort. (Ex: uncontrolled bleeding, ruptured abdominal aortic aneurysm)
- ☐ 6 – A declared brain-dead patient. Patient is an organ donor.

MALLAMPATI SCORE

☐ Class I – Complete visualization of soft palate	☐ Class III – Visualization of only the base of the uvula	☐ Neck ROM
☐ Class II – Complete visualization of the uvula	☐ Class IV – Soft palate is not visible at all	__________

TYPE OF ANESTHESIA

☐ Monitored Anesthesia Care (MAC) ☐ Moderate Sedation

☐ Total Intravenous Anesthesia (TIVA) ☐ Other: ______________________________

Physician's/Licensed Independent Practitioner's Statement:

I have discussed the anesthetic plan with the patient/guardian including risks/benefits/alternatives of the anesthetic plan. The patient has had all questions answered and has agreed to proceed. I have completed a reassessment immediately before induction of anesthesia/sedation, and the patient remains a candidate for the anesthetic plan.

____

Anesthesiologist/Physician/Licensed Independent Practitioner/CRNA -Signature **Date / Time**