South Broward
Endoscopy
11011 Sheridan Street, Suite 106
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# Medical Questionnaire

Patient Name: ______________________________ Date: ______________
Emergency Contact: ______________________________ Phone # ______________
Name of Person accompanying patient home: ______________________ Phone # ______________
Will escort remain at Center? ❑ Yes ❑ No Patient Age: ________ Height: __________ Weight: __________
Primary M.D.: ____________________ Surgeon/Physician for Procedure: ______________________
Primary Language: ________________ Understands English ❑ YES ❑ NO Requires Translator ❑ YES ❑ NO

**MEDICAL HISTORY:** *Check all that apply* ❑ **DENIES MEDICAL PROBLEMS**

***Neurology:*** ❑ NONE
❑ Stroke ________ ❑ Seizures ________ ❑ Depression ❑ Head Injury ❑ Other____________

***Cardiovascular:*** ❑ NONE
❑ MI/Heart Attack ❑ High Blood Pressure ❑ Mitral Valve Prolapse ❑ Chest Pain
❑ Heart Valve Replacement ________ ❑ CHF ❑ Pacemaker ❑ Stent ❑ Open Heart Surgery ________
❑ Arrhythmia/Palpitations ❑ Internal Defibrilator Manufacturer: ________________
❑ Vascular Disease ❑ Perpheral Vascular Disease ❑ Coronary Artery Disease ________

***EENT:*** ❑ NONE
❑ Glaucoma ❑ YES ❑ NO ❑ Loose Teeth ❑ YES ❑ NO ❑ Other ________________

***Respiratory:*** ❑ NONE
❑ Asthma ________ ❑ COPD/Emphysema ❑ Pneumonia ________ ❑ Bronchitis ________
❑ Sleep Apnea ❑ Shortness of Breath ❑ Other: ________________

***Hepatic:*** ❑ NONE
❑ Hepatitis Type (*please circle*) A B C ❑ Bleeding Disorder: Type ________________
❑ Other Liver Disease: Type ________________

***GI:*** ❑ NONE
❑ GERD (Gastroesophageal Reflux Disease) ❑ Hiatal Hernia ❑ Ulcer ________ ❑ Crohn's/Colitis
❑ History of Colon Polyps ❑ Recent change in Appetite/Weight ❑ Trouble Swallowing ❑ Other: ________

***Renal:*** ❑ NONE
❑ Prostate ❑ Dialysis, Date of Last Treatment: ________ ❑ Kidney Disease: Type ____________

***Endocrine:*** ❑ NONE
❑ Type I Diabetes (Insulin Dependent) ❑ Type II Diabetes (Non-Insulin Dependent) ❑ Thyroid Disease

***Cancer:*** ❑ NONE
❑ Type: ________________ Date & Type of Treatment: ________________

***GYN:*** ❑ NONE
❑ Last menstrual period: Date ________ ❑ Tubal Ligation/IUD ❑ Hysterectomy

***Musculoskeletal:*** ❑ NONE
❑ Arthritis ❑ Fractures ❑ Back/Disk Disease ❑ Artificial Joint/Prosthetic: Type____________
❑ Limited Motion of Neck ❑ TMJ - Limited Jaw Movement

**SURGERIES/PROCEDURES:** ❑ NONE

| Procedure | Date |
|---|---|
| | |
| | |
| | |
| | |

**ALLERGIES:** **TYPE OF REACTION:**

____________________________________________
____________________________________________
____________________________________________

❑ Medicines ❑ Food ❑ Environmental ❑ Latex ❑ **No Known Allergies**

Patient / Label

**MEDICATIONS**: ❑ None ❑ See Attach List

| Drug | Dosage | Last dosage |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

| | | |
|---|---|---|
| Aspirin in the last week | ❑ YES | ❑ NO |
| Coumadin or Plavix in the last week | ❑ YES | ❑ NO |
| Motrin, Aleve, Advil in the last week | ❑ YES | ❑ NO |

**TOBACCO**: ❑ None ❑ _______ packs per day ❑ _______ # of years ❑ ________ Years Quit

**ALCOHOL**: ❑ None ❑ _______ Drinks per week ❑ Type: ____________ ❑ ________ Years Quit

**RECREATIONAL/STREET DRUGS**: ❑ None ❑ Type: ____________ ❑ ________ Years Quit

**PREVIOUS ANESTHESIA**: ❑ YES ❑ NO

Problems with Anesthesia ❑ YES* ❑ NO Family History of Problems with Anesthesia ❑ YES* ❑ NO

*Describe Problems: ____________________________________________

**RECENT EXPOSURE/SYMPTOMS TO INFECTIOUS DISEASE**: Any History of Infectious Disease? ❑ YES* ❑ NO

*List: ______________________ ❑ HIV/AIDS ❑ C-Diff ❑ Swine Flu/H1N1 ❑ TB ❑ MRSA ❑ Avian Flu

❑ Other ____________________________________

**DO NOT WRITE BELOW THIS LINE - FOR ADMINISTRATIVE USE ONLY**

## DISPOSITION OF BELONGINGS

| | | | |
|---|---|---|---|
| Jewelry Removed | ❑ N/A | ❑ YES | ❑ NO |
| Dentures Removed | ❑ N/A | ❑ Upper<br>❑ Both | ❑ Lower |
| Glasses/Contacts | ❑ N/A | ❑ Left<br>❑ Removed | ❑ Right |
| Hearing Aid | ❑ N/A | ❑ Left<br>❑ Removed | ❑ Right |

Disposition of Belongings:
❑ At Bedside ❑ With Patient ❑ Family
❑ Managers Office

## NURSES NOTES / COMMENTS / EXPLAIN ALL * ITEMS

## CARE PLAN AND EDUCATIONAL TEACHING RECORD

| NURSING DIAGNOSIS | PLAN / IMPLEMENT | EVALUATION |
|---|---|---|
| 1. ❑ Actual ❑ Potential<br>Knowledge deficit re:<br>Pre & Post Procedure<br>Patient Safety | ❑ Orient to unit<br>❑ Refer to physician/anesthesia provider for additional questions.<br>❑ Provide information in layman's terms.<br>❑ Other ______________ | ❑ Patient demonstrates greater knowledge of procedure, care and safety |
| 2. ❑ Actual ❑ Potential<br>Barriers to Learning related to:<br>❑ Communication/Language<br>❑ Ability to read/write<br>❑ Physical status i.e. acute pain<br>❑ Emotional Status<br>❑ Impaired mental status<br>❑ None - Ready to Learn | ❑ Learning needs assessed.<br>❑ Establish appropriate communication.<br>❑ Provide education to patient/family/significant other when readiness to learn is established.<br>❑ Other ______________ | ❑ Safe discharge plan implemented<br>❑ Learning needs met |

Patient Signature ____________ Date ____________

RN - Printed Name ____________ RN Signature ____________ Date / Time ____________