

**PORTLAND ENDOSCOPY CENTER**  
Confidential Nursing Records

<b>OFFICE USE ONLY</b>
INS. _____
_____
Endo # _____

**PLEASE COMPLETE AND MAIL TO FACILITY BEFORE PROCEDURE**

Patient's full name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Mailing address: \_\_\_\_\_ Sex: Male/Female \_\_\_\_\_ Marital Status \_\_\_\_\_  
 City/State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (work)

Physicians you would like to receive a copy of your report:

**Medication allergies (including LATEX):**  
**Name Reaction**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**What type of symptoms are you having? (please circle)**

difficulty swallowing	black/bloody stools
heartburn	change in bowel habit
nausea/vomiting	constipation
indigestion	diarrhea
abdominal pain/cramps	rectal bleeding
history of ulcers	weight loss
other: _____	history of colon polyps /cancer screening

**Circle those which pertain to you:**

heart disease*	glaucoma
high blood pressure*	artificial joint
pacemaker*	blood trans.
heart valve*	cancer
I.C.D./ defibrillator*	seizures
respiratory problems*	liver disease
diabetes B/S _____	kidney disease
	infectious condition

Physical disabilities NO / YES Explain: \_\_\_\_\_

Dentures Hearing Aid Glasses Other \_\_\_\_\_

Do you smoke? YES / NO Daily alcoholic beverages? \_\_\_\_\_

I agree the above medical information is accurate.  
 Signed: \_\_\_\_\_

List of current medications you are now taking\*

Name	Dose	Frequency

Have you ever had a drug resistant infection? YES NO

Do you take aspirin, aspirin products or blood thinners?  
 If yes, last time taken: \_\_\_\_\_

Are you pregnant?: YES NO N/A

List surgeries and dates:	Other medical problems:

Do you have an advance directive? YES NO  
 If yes, please mail a copy with this form. If your procedure is too soon for you to provide a copy via mail, please bring a copy with you on the date of your procedure.

Any problems with anesthesia?\* YES NO

Anyone in your immediate family been diagnosed with: colon cancer? polyps? inflammatory bowel? Colitis? Crohn's? Irritable bowel syndrome?  
 Whom? \_\_\_\_\_ Age Diagnosed \_\_\_\_\_

**\*\*\* FOR OFFICE USE ONLY \*\*\***

**NURSING DATA** Date \_\_\_\_\_  
 Bed# \_\_\_\_\_ Dr. \_\_\_\_\_  
 Mental Status: \_\_\_calm \_\_\_ apprehensive Permit Signed \_\_\_\_\_  
 Prep: Co / Go / Half / Nu / Trilytely-Movi Prep - Fleets Enema  
 Miralax Results: good / fair Diet: C/L NPŌ \_\_\_\_\_  
 Escort: \_\_\_\_\_ Relationship: \_\_\_\_\_ Waiting Y/N M.D. Y/N  
 Will return @ \_\_\_\_\_ Call @ \_\_\_\_\_  
 Assessment: \_\_\_\_\_  
 \_\_\_\_\_ R.N.  
 I.V. \_\_\_\_\_ Site \_\_\_\_\_ ga# \_\_\_\_\_ Buff. Lidocaine \_\_\_\_\_  
 \_\_\_\_\_ R.N.

**Patient has received and reviewed a copy of the Patient Rights and Responsibilities YES / NO**  
 (if no, please provide before patient signs consent for procedure)

**PHYSICAL EXAM**

BMI: \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_  
 V/S: B/p \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ O<sub>2</sub>Sa \_\_\_\_\_  
 HEENT \_\_\_\_\_ Abd \_\_\_\_\_  
 Heart \_\_\_\_\_ Extrem. \_\_\_\_\_  
 Chest \_\_\_\_\_ Neuro \_\_\_\_\_  
 Rectal \_\_\_\_\_  
 \_\_\_\_\_ M.D.

**MEDICATIONS\***

Circle medications patient took today.

**HEART DISEASE\***

Have you ever had problems with your heart? YES NO

If yes, have you ever had a heart attack? YES NO

If yes, when? \_\_\_\_\_

Do you ever get chest pain? YES NO

Have you had any problems with heart rhythm? YES NO

If yes, what kind? \_\_\_\_\_

Have you ever had any heart procedures? YES NO

If yes, what kind? \_\_\_\_\_

Have you ever had a stress test? YES NO

**ANESTHESIA PROBLEMS\***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RESPIRATORY\***

Do you have any respiratory or breathing problems? YES NO

If yes, what kind? \_\_\_\_\_

Have you ever been a smoker? YES NO

If quit, when? \_\_\_\_\_

Do you smoke now? YES NO

If yes, how much? \_\_\_\_\_

Do you have asthma? YES NO

**AIRWAY\***

Do you snore? YES NO

Do you use a C-PAP? YES NO