

## OUTPATIENT ENDOSCOPY INSTRUCTIONS

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Procedure scheduled for:

☐ Hoag Endoscopy Center

949-698-1339



Newport Beach Endoscopy Center

949-646-6999

☐ Upper Endoscopy Procedure

☐ Lower Endoscopy Procedure

Date: \_\_\_\_\_ Check in Time: \_\_\_\_\_ A.M./P.M. Procedure: \_\_\_\_\_ A.M./P.M.

**If your medical history includes any of the following, please call the facility:**

- Active Shingles
- MRSA (Methicillin-resistant Staphylococcus aureus)
- Clostridium difficile (Often called C. difficile or C. diff.)
- Dialysis

### Preparing for your procedure

- **Items to bring** with you on the day of the procedure:
  - Completed Patient History Questionnaire
  - Completed Patient's Home Medication List
  - Insurance cards and another form of ID
  - Any payment as required by your insurance provider (cash, check, credit card)
- Bring this form with you on the day of the procedure.
- Do not wear nylons/stockings, body piercing or jewelry.
- Wear loose clothing and low-heeled shoes. Your clothes will be folded and placed in a plastic belonging bag during your procedure.
- Please make sure to follow your procedure instructions that you received from your doctor. If you should have any problems or questions regarding your procedure instructions, please contact your doctor.
- Due to sedation medications during the procedure, you **must have someone drive you home or your procedure will be canceled. NOTE: The driver cannot be a cab or taxi.**
- If you have family members that want to speak with the physician, please have them wait in the waiting room. Family waiting can check in with front-desk staff in the lobby.

### Center Information

- If you have an Advance Directive or Living Will, please bring a copy with you the day of the procedure. The document will be placed in your medical record in the event that there is a patient transfer or emergent situation. If you need additional information regarding Advance Directives will be happy to provide you with official State Advance Directive forms.
- The following physicians have ownership in Hoag Endoscopy Center and Newport Beach Endoscopy Center: Donald Abrahm, M.D., David J Kaufman, D.O., Christopher Evan Lee, M.D., Babak N. Rad, M.D., Abhay S. Parikh, M.D., S. Patricia Tsai, M.D., Lino J. DeGuzman, M.D., Daniel A. Ng, M.D., Richard Quist, M.D., Kathryn Ross, M.D., and Homeira Mehrabian, M.D.

## ☐ HOAG ENDOSCOPY CENTER

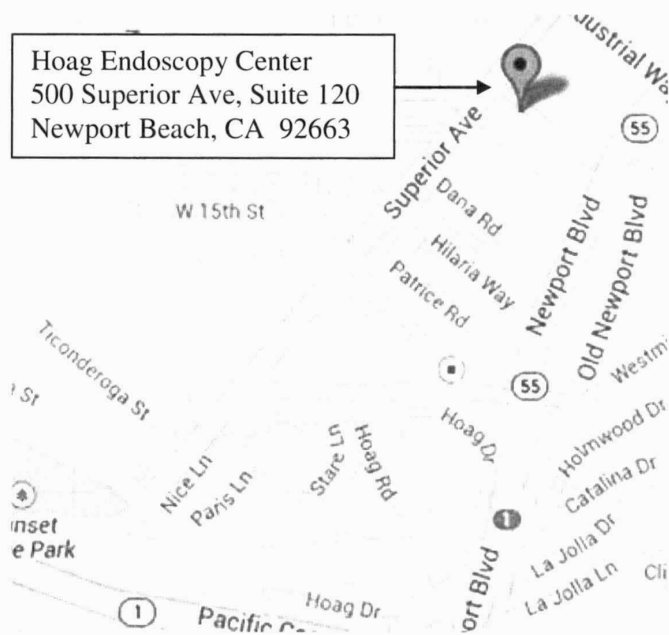
### Parking

#### Hoag Endoscopy Center at Hoag Health Center – Newport Beach

There is ample parking in both parking structures at Hoag Health Center – Newport Beach. Registration is located on-site in the Hoag Endoscopy Center.

### Questions?

**Hoag Endoscopy Center**  
949-698-1339



## ☒ NEWPORT BEACH ENDOSCOPY CENTER

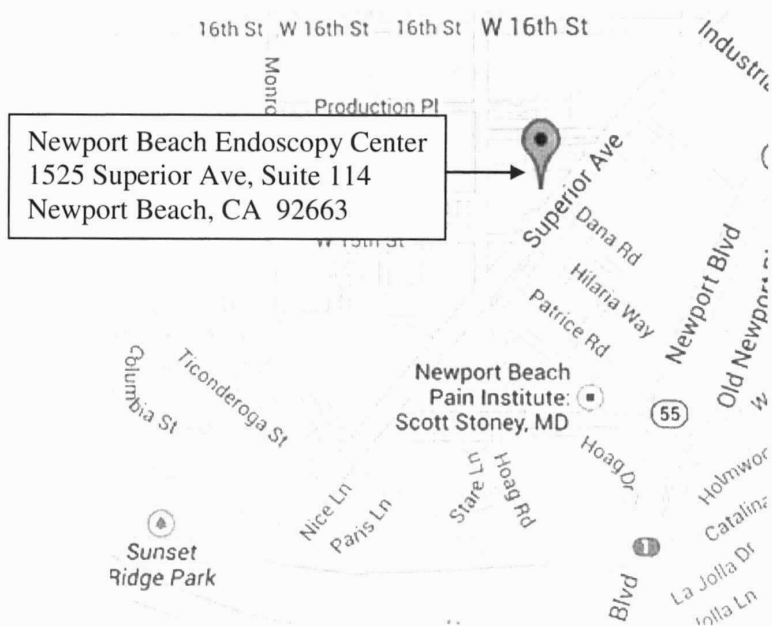
### Parking

#### Newport Beach Endoscopy Center – 1525 Superior Ave

There is ample in parking in both the top floor level parking as well as in the lower garage. Registration is located on-site in the Newport Beach Endoscopy Center.

### Questions?

**Newport Beach  
Endoscopy Center**  
949-646-6999



## PATIENT HISTORY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Stated Height: \_\_\_\_\_ Stated Weight: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Driver(s) Name: \_\_\_\_\_  
 Driver(s) Telephone Numbers: 1<sup>st</sup> Number ( ) \_\_\_\_\_ 2<sup>nd</sup> Number ( ) \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_  
 Physician performing procedure: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Internist: \_\_\_\_\_ Last seen: \_\_\_\_\_ Cardiologist: \_\_\_\_\_ Last seen: \_\_\_\_\_

### ALLERGIES and ALLERGY REACTIONS:

LIST PREVIOUS SURGERIES:	Year	Complications	Type of Anesthesia

LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES:	Year	angioplasty/stent placement, echocardiogram, stress test, pacemaker or defibrillator model/brand #, and where done

Please check appropriate box in each section below:

<b>CARDIOVASCULAR</b>			Yes	No				Yes	No
Hypertension			<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain			<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack – Date: _____			<input type="checkbox"/>	<input type="checkbox"/>	Pain or shortness of breath when				
Coronary Artery Disease			<input type="checkbox"/>	<input type="checkbox"/>	walking 2 blocks or				
Cardiomyopathy			<input type="checkbox"/>	<input type="checkbox"/>	climbing 1 flight of stairs			<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure			<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol			<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias i.e. A-Fib			<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation in lower extremities			<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever			<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease			<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve problems			<input type="checkbox"/>	<input type="checkbox"/>	(age of onset)				
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	Father    Mother    Siblings				
Carotid Artery Disease			<input type="checkbox"/>	<input type="checkbox"/>	_____				
<b>PULMONARY</b>			Yes	No				Yes	No
Asthma			<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in lungs or legs			<input type="checkbox"/>	<input type="checkbox"/>
COPD/Bronchitis/Emphysema (circle)			<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea			<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough			<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Use			<input type="checkbox"/>	<input type="checkbox"/>

### PATIENT HISTORY QUESTIONNAIRE

3277      Side 1 of 2      Rev 09/09/14

Addressograph

<b>GASTROINTESTINAL</b> Hiatal Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers/GERD/Gastric Reflux (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No Gallstones <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis A, B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>GENITOURINARY</b> Urinary Tract Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Stones <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Penile Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HEMATOLOGIC</b> Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Diseases i.e. Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No Easy Bruising <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>ENDOCRINE</b> Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Hypo/Hyperthyroidism <input type="checkbox"/> Yes <input type="checkbox"/> No Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>NEUROLOGIC</b> Stroke/TIA's <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Myasthenia Gravis <input type="checkbox"/> Yes <input type="checkbox"/> No Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No Headache <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>PAIN</b> Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoarthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Pain Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Back/Neck Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____
<b>GENERAL HEALTHCARE</b> Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____ Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No Immune Deficiency <input type="checkbox"/> Yes <input type="checkbox"/> No TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<b>Social History:</b> Do you drink alcohol? Amount: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you ever smoke? Years: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Have you smoked in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ <b>If female: possibility of pregnancy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Last menstrual period:</b> _____ History of Malignant Hyperthermia (MH) <input type="checkbox"/> Yes <input type="checkbox"/> No Family history of anesthesia problems or MH (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>SURGICAL INFORMATION</b> Do you have any specific needs? Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No Vision <input type="checkbox"/> Yes <input type="checkbox"/> No Living alone <input type="checkbox"/> Yes <input type="checkbox"/> No Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	Do you need information on: Current surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Medications <input type="checkbox"/> Yes <input type="checkbox"/> No Activities <input type="checkbox"/> Yes <input type="checkbox"/> No Home Care <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have caps, bridges, dentures or loose teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
[Patient/Parent/Conservator/Guardian]

\_\_\_\_\_  
[If completed by other than patient, indicate relationship]

\_\_\_\_\_  
[Date]

**THIS SECTION FOR FACILITY PERSONNEL USE ONLY**

\_\_\_\_\_  
[Reviewed by Assessment Nurse]

\_\_\_\_\_  
[Date]

\_\_\_\_\_  
[Time]

**Acknowledgement:** I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information.

<b>Discharge – Additional Prescriptions and Specific Medication Instructions:</b>	
<input type="checkbox"/>	No changes in prescription and non-prescription medications.
1.	
2.	

[Patient/Parent/Conservator/Guardian]	[Date]	[Time] A.M./P.M.
[Physician Signature]	[Date]	[Time] A.M./P.M.